DOCUMENT RESUME

ED 277 969 CG 019 651

TITLE	Hunger and the Elderly. Joint Hearing before the Domestic Task Force of the Select Committee on Hunger and the Select Committee on Aging. House of Representatives, Ninety-Ninth Congress, Second Session.
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
REPORT NO	House-Comm-Pub-99-572
PUB DATE	22 Apr 86
NOTE	115p.; Serial No. 99-15. Much of document contains small print.
AVAILABLE FROM	Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	Dietetics; *Eating Habits; Federal Aid; Federal Programs; Food; Hearings; *Hunger; *Low Income Groups; *Nutrition; *Older Adults; *Poverty
IDENTIFIERS	Congress 99th

ABSTRACT

This document contains witness testimonies and prepared statements from the Congressional hearing called to examine the issue of hunger and the elderly. Opening statements are included from Representatives Dennis Hertel, Mickey Leland, Jim Lightfoot, John McCain, Leon Panetta, Thomas Ridge, Marge Roukema, Edward Roybal, and Bill Schuette. William Hutton, the executive director of the National Council of Senior Citizens, examines socioeconomic trends which demonstrate the increased risk of hunger among the elderly poor. Other witnesses providing testimony include: (1) Rosalie Abrams, a state senator and director of the Maryland State Office on Aging; (2) Adelaide Carpenter, a volunteer for the Polk County Elderly Feeding Program in Des Moines, Iowa; (3) John Driggs, the chairman of Western Savings and Loan in Phoenix, Arizona; (4) David Lipschitz, the director of Geriatric Research Education and Clinical Center, John L. McClellan Memorial Veterans Hospital in Little Rock, Arkansas; (5) Bill Moyer, director of the King County Nutrition Project in Seattle, Washington; and (6) Michio Suzuki, the associate commissioner of the Office of State and Tribal Programs, Administration on Aging. Those witnesses who work with the elderly poor give concrete examples of the magnitude of the problem of hunger among the elderly. Perspectives on the programmatic issues involved are provided, including the impact of recent reductions in federal spending on the unmet need, as well as evidence that shortsighted nutrition reductions can in the long run mean higher spending on other programs. Prepared statements, letters, and supplemental materials are included. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

HUNGER AND THE ELDERLY

JOINT HEARING

BEFORE THE

DOMESTIC TASK FORCE

OF THE

SELECT COMMITTEE ON HUNGER

AND THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 22, 1986

Serial No. 99-15

Printed for the use of the Select Committee on Hunger

Comm. Pub. No. 99-572

Printed for the use of the Select Committee on Aging

ED277969

CE 019 611

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

U.S. GOVERNMENT PRINTING OFFICE

61-275 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

SELECT COMMITTEE ON HUNGER

MICKEY LELAND, Texas, *Chairman*

TONY P. HALL, Ohio
BOB TRAXLER, Michigan
LEON E. PANETTA, California
THOMAS A. DASCHLE, South Dakota
VIC FAZIO, California
SAM GEJDENSON, Connecticut
PETER H. KOSTMAYER, Pennsylvania
SALA BURTON, California
BYRON L. DORGAN, North Dakota
MARGE ROUKEMA, New Jersey
BILL EMERSON, Missouri
SID MORRISON, Washington
BENJAMIN A. GILMAN, New York
COOPER EVANS, Iowa
ROBERT F. (BOB) SMITH, Oregon
DOUG BEREUTER, Nebraska

DOMESTIC TASK FORCE

LEON E. PANETTA, California, *Chairman*

BOB TRAXLER, Michigan
SAM GEJDENSON, Connecticut
SALA BURTON, California
MICKEY LELAND, Texas
(Ex Officio)
BILL EMERSON, Missouri
SID MORRISON, Washington
MARGE ROUKEMA, New Jersey
(Ex Officio)

PROFESSIONAL STAFF
MIRANDA G. KATSOYANNIS, *Chief of Staff*
JOHN D. CUTTELL, *Minority Staff Director*

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, JR., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
RICK BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MACKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
ROBERT E. WISE, JR., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
TOMMY F. ROBINSON, Arkansas
RICHARD H. STALLINGS, Idaho

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona
BILL SCHUETTE, Michigan
FLOYD SPENCE, South Carolina

FERNANDO TORRES-GIL, *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

CONTENTS

	Page
Hearing held in Washington, DC, April 22, 1986	1
Statement of:	
Abrams, Rosalie, State senator, director, Maryland State Office on Aging	39
Carpenter, Adelaide, volunteer, Polk County Elderly Feeding Program, Des Moines, IA	22
Driggs, John, chairman, Western Savings and Loan, Phoenix, AZ	10
Hertel, Hon. Dennis M., a Representative in Congress from the State of Michigan, opening statement of	6
Hutton, William R., executive director, National Council of Senior Citizens, accompanied by Edith Kassner, senior research assistant	8
Leland, Hon. Mickey, a Representative in Congress from the State of Texas, opening statement of	4
Lightfoot, Hon. Jim, a Representative in Congress from the State of Iowa, opening statement of	6
Lipschitz, David, M.D., director, Geriatric Research Education and Clinical Center, John L. McClellan Memorial Veterans Hospital, Little Rock, AR	27
McCain, Hon. John, a Representative in Congress from the State of Arizona, opening statement of	7
Moyer, Bill, director, King County Nutrition Project, Seattle, WA	45
Panetta, Hon. Leon E., a Representative in Congress from the State of California, opening statement of	1
Ridge, Hon. Thomas J., a Representative in Congress from the State of Pennsylvania, opening statement of	7
Roukema, Hon. Marge, a Representative in Congress from the State of New Jersey, opening statement of	5
Roybal, Hon. Edward R., a Representative in Congress from the State of California, opening statement of	3
Schuette, Hon. Bill, a Representative in Congress from the State of Michigan, opening statement of	6
Suzuki, Michio, Associate Commissioner, Office of State and Tribal Programs, Administration on Aging	43
Prepared statements, letters, supplemental material, et cetera:	
Abrams, Rosalie, State senator, director, Maryland State Office on Aging:	
Prepared statement of	87
Responses to questions submitted by:	
Hon. Mickey Leland	42
Hon. Leon E. Panetta	41
Bentley, Hon. Helen Delich, a Representative in Congress from the State of Maryland, prepared statement of	62
Bobbitt, O. P. (Bob), executive director, Texas Department on Aging:	
Letter to Chairman Leland, dated April 9, 1986	101
Testimony on hunger and the elderly in Texas	102
Carpenter, Adelaide, volunteer, Elderly Feeding Pilot Project, Polk County, IA:	
Prepared statement of	71
Responses to questions submitted by:	
Hon. Mickey Leland	27
Hon. Leon Panetta	26
Driggs, John, chairman, Western Savings and Loan, Phoenix, AZ, responses to questions submitted by Hon. Mickey Leland	13
Emerson, Hon. Bill, a Representative in Congress from the State of Missouri, prepared statement of	57

Page

Prepared statements, letters, supplemental material, et cetera—Continued
Flisher, Velma, program manager, Supplemental Food Programs, Polk County, IA, prepared statement of 78
Hammerschmidt, Hon. John Paul, a Representative in Congress from the State of Arkansas, prepared statement of 60
Hunger and the elderly, Select Committee on Hunger 46
Hutton, William R., executive director, National Council of Senior Citizens, prepared statement of 64
Lightfoot, Hon. Jim, a Representative in Congress from the State of Iowa, prepared statement of 55
Lipschitz, Dr. David A., director, Geriatric Research Education and Clinical Center, John L. McClelland Memorial Veterans Hospital and professor of medicine, director, Division on Aging, University of Arkansas for Medical Sciences, prepared statement of 73
Moyer, Bill, past president, National Association of Nutrition and Aging Services Programs, Seattle, WA:
Prepared statement of 83
Responses to questions submitted by:
Hon. Mickey Leland 38
Hon. Leon Panetta 36
Panetta, Hon. Leon E., a Representative in Congress from the State of California, Dear Colleague letter dated February 24, 1986 50
Rinaldo, Hon. Matthew J., a Representative in Congress from the State of New Jersey, prepared statement of 58
Roukema, Hon. Marge, a Representative in Congress from the State of New Jersey, prepared statement of 53
Roybal, Hon. Edward R., a Representative in Congress from the State of California, "Widening Hunger Among Elderly Poor Poses Health Threat," news release entitled, dated April 22, 1986 52
Sullivan, Louis, M.D., president and dean, Morehouse School of Medicine, Atlanta, GA, and vice president, Association of Minority Health Professions Schools, on behalf of the National Health Coalition for Minorities and the Poor, prepared statement of 108
Suzuki, Michio, Associate Commissioner, State and Tribal Programs, Administration on Aging:
Prepared statement of 97
Responses to questions submitted by Hon. Leon Panetta 44
Tauke, Hon. Tom, a Representative in Congress from the State of Iowa, prepared statement of 63

HUNGER AND THE ELDERLY

TUESDAY, APRIL 22, 1986

HOUSE OF REPRESENTATIVES, DOMESTIC TASK FORCE OF THE SELECT COMMITTEE ON HUNGER AND THE SELECT COMMITTEE ON AGING,

Washington, DC.

The committees met, pursuant to notice, at 2 p.m., in room 311, Cannon House Office Building, Hon. Leon E. Panetta (chairman, Domestic Task Force, Select Committee on Hunger) and Hon. Edward R. Roybal (chairman, Select Committee on Aging) presiding.

Members present: Representatives Leland, Roybal, Hertel, Roukema, Schneider, Ridge, McCain, Bentley, Lightfoot, and Schuette.

OPENING STATEMENT OF HON. LEON E. PANETTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. PANETTA. The Select Committee on Hunger and the Domestic Task Force is now convened, in participation with the Select Committees on Hunger and Aging for the purpose of this hearing today, to hear testimony on one of the problems our society too often ignores, which is hunger among the elderly.

In recent years there has been a great deal of publicity about the improved economic status of the elderly. And that publicity is warranted. The Select Committee on Aging, under the leadership of Ed Roybal, deserves much credit for fighting to ensure the economic gains made by the elderly over the past two decades are not eroded during the current preoccupation with deficits.

We all know that three of the great success stories in social programs in the past two decades have been significant in improving the economic status of the elderly. These success stories are the protection of Social Security benefits against inflation, creation of the Medicare and Medicaid Programs, and the establishment of the Supplemental Security Income Program.

Nevertheless, we should not forget that to say that a rising tide lifts all boats doesn't apply if you don't even have a lifeboat. Tragically, millions of elderly Americans don't have those lifeboats. While the poverty rate among the elderly has declined dramatically in the past two decades, poverty remains unacceptably high among certain groups of elderly Americans, particularly widows, and those over the age of 85.

Even though the average Social Security benefit is $429 a month, millions of elderly persons have Social Security benefits well below that level.

For example, the average widow's benefit in December 1985 was $215. Supplemental Security Income Program does not guarantee

elderly Americans will even have poverty level incomes. In fact, for Social Security recipients receiving both the Federal SSI payment and food stamps the combined benefit is only 84 percent of the poverty level.

Last year in the Food Security Act the Agriculture Committee reauthorized the Nutrition Assistance Programs. We were able to achieve some modest restorations of benefit cuts that were made in 1981 and 1982, and some modest benefit improvements. This progress in large part was possible because there is now an increased awareness in this Nation that hunger does indeed exist.

The Select Committee on Hunger deserves significant credit for fostering a climate of awareness that hunger remains a problem, and as a compassionate people, we simply cannot ignore this problem.

Unfortunately, the awareness that hunger is a problem is less than universal. Frankly, I was shocked to discover during testimony by the Administrator of the Food and Nutrition Service that the recommendations of the President's Task Force on Hunger were apparently not taken seriously in the executive branch. Last year the Congress approved an increase in the asset limit for food stamp recipients. This change was particularly important for many elderly Americans whose life savings put them only a bit above the previous asset limitation. Even though the increase in the asset limit in the Food Security Act was less than what the President's own Task Force on Hunger had recommended, the President now proposes repeal of that increase.

And, furthermore, the Administrator of the Food and Nutrition Service does not consider the recommendations of that task force in any sense binding when it comes to putting together the proposed budget.

We were also shocked to discover that even though the Department of Agriculture is holding unprecedented commodity surpluses, including 600 million pounds of cheese, Department of Agriculture is placing significant obstacles in the path of many dedicated State and local government officials, as well as representatives of private organizations, to try to get this surplus food to needy elderly Americans.

Testimony we received from one commodity distribution project in Detroit, Focus Hope, has a waiting list of 16,001 elderly persons waiting to be able to receive food through this program.

Right now for a person on this waiting list to get commodities, a person currently getting them must die, move away, or go into a nursing home. Apparently this approach is too generous for many of the administration's budget cutters who propose that once a person currently getting commodities stops getting them, no one will be able to take their place.

One issue which the budgeteers should carefully examine is whether specific cuts might not be penny wise and pound foolish. I submit that this can often be the case if nutrition assistance of elderly Americans is reduced.

One example is home delivery of congregate meals, which may enable elderly persons to remain in their homes rather than becoming institutionalized. We should not forget 40 percent of Medicaid spending goes for nursing home care of the elderly. To the

extent the nutrition program assists persons to live independently, we have the potential to avert significant State and Federal costs.

Another example is illness among the elderly due to malnutrition, which can increase costs in both Medicare and Medicaid. And while nutritional studies of the low-income elderly are very limited, existing studies do document severe calorie malnutrition.

It is an indictment of our priorities as a civilized Nation if a person of any age goes hungry. The indictment is even more stark in an economy such as ours in which a major public policy issue is how to deal with huge agricultural surpluses. Furthermore, if we tolerate hunger among the elderly, we show ourselves to be a society so lacking in gratitude that we allow our parents and grandparents who struggled through the Great Depression and then fought in World War II to somehow now go hungry.

In a few weeks there will be a national effort to bring attention to domestic hunger needs in so-called Hands Across America Campaign. I want to make sure that this effort addresses the needs of all ages in our society.

This afternoon we're privileged to obtain testimony which deals with three aspects of the problem of hunger among the elderly.

First, a good friend of this committee, Bill Hutton, the executive director of the National Council of Senior Citizens will brief us on social-economic trends, which demonstrate the increased risk of hunger among the elderly poor.

Second, some dedicated people who work with the elderly poor will give us concrete examples of the magnitude of the problem.

And, finally, some prospectives on the programmatic issues involved will be provided, including the impact of recent reductions in Federal spending on the unmet need, as well as some evidence on how shortsighted nutrition reductions can in the long run mean higher spending in other programs.

Mr. Roybal, do you have a statement?

[Material submitted by Mr. Panetta appears at the conclusion of the hearing, see p. 50.]

OPENING STATEMENT OF HON. EDWARD R. ROYBAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. ROYBAL. Thank you, Mr. Chairman.

I would like to take this opportunity to commend you, Mr. Panetta, and also Mr. Leland, for your insight and leadership in calling this important hearing to examine hunger and malnourishment among the older American population of the United States. While it is tragic that we still have to do much more before we have eliminated hunger from our society, many of the successes that we've had in reducing hunger can be traced to the deep commitment and skilled leadership of both Mr. Leland and Mr. Panetta, and many other members of the Select Committee on Hunger.

I appreciate the opportunity to join their efforts today, and look forward to working together in the future to develop policy proposals which better meet the nutritional needs of older Americans.

Today's hearing will focus particular attention on those poor, isolated, and frail individuals whose very health and well-being is severely threatened by malnutrition. Given the wealth of medical re-

search linking poor nutrition to a variety of health problems, it is crucial to reexamine the scope of hunger among our elderly population, and to assess the adequacy of Federal nutrition programs to meet the growing need.

We are fortunate to have with us today a distinguished panel of witnesses representing a wide cross section of the country. I look forward, Mr. Chairman, to hearing their expert testimony, and to receiving their specific recommendations.

Thank you, Mr. Panetta.

[News release submitted by Mr. Roybal appears at the conclusion of the hearing, see p. 52.]

Mr. PANETTA. Thank you, Mr. Roybal.

Mrs. Schneider.

Go ahead, Mickey.

OPENING STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Chairman LELAND. Thank you, Mr. Chairman, very much. Good afternoon, I would like to welcome the witnesses, and particularly thank those of you who traveled long distances to testify today.

I also would like to thank Chairman Roybal and members of the Select Committee on Aging for working with us on this examination of hunger among the elderly. And I'm especially pleased, of course, with the leadership that's offered by our chairman of the Domestic Task Force, Mr. Panetta, who has been the champion of not just the elderly, but all persons who are hungry in this country.

National trends can camouflage the realities of hunger in America.

While the overall elderly poverty rate has declined significantly, 1 in 8, or 3.3 million elderly still live in poverty. Despite the successful expansion of our Social Security System, the elderly in poverty struggle each day to balance their high food, shelter, and medical expenses.

The National Health and Nutrition Examination Survey, conducted from 1976 to 1980, demonstrated that all elderly persons are at risk of nutritional deficiencies, but particularly those living in poverty.

The survey found that 1 in 4 of the elderly poor consume less than 1,000 calories daily. Poverty is the most significant factor associated with this low-food intake.

While there are no up-to-date national nutritional surveys of the elderly, several State and local surveys indicate that hunger remains a serious and frequent problem among this population group. At a Select Committee on Hunger hearing last November, a representative from the New York State Department of Health presented alarming findings of a State survey on hunger among the homebound elderly. Among those living in poverty who were not receiving home delivered meals, 1 in 5 were routinely going without food for 1 or more days each week.

In my home State of Texas, the Department of Aging estimates 100,000 mobile elderly, and 16,000 homebound elderly need nutrition services, but are not able to get them due to limited funds.This

large unmet need exists in Texas despite the State's supplemental funding for elderly meals in title XX of the Social Security Act and their recent State omnibus hunger legislation.

I was contacted last week by the Texas Department of Aging with grim news. If USDA does not raise the reimbursement rate per meals served in fiscal year 1985 to 56.76 cents, as provided for in Federal appropriations and authorization, Texas will have to cut the program by 300,000 meals. An additional 6,000 homebound elderly may soon lose the one home delivered meal they depend on each day because of the Gramm-Rudman-Hollings cuts in title XX.

We have found the Commodity Supplemental Food Program and the title III–C nutrition programs to be successful in improving the nutritional status and well-being of poor elderly. The Department of Agriculture has limited the amount of commodities available to feed the elderly despite the availability of funds. We cannot sit passively while elderly Americans go without food for days at a time, and millions of pounds of food commodities go unused.

I look forward to hearing recommendations today that will allow the Federal Government to renew its commitment to abolishing hunger among the elderly.

Thank you, Mr. Chairman.

Mr. PANETTA. Mrs. Roukema.

OPENING STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mrs. ROUKEMA. I would first like to express my regret at having to leave here because I have a markup in the Banking Committee. But I do want to underscore what Mr. Panetta, Mr. Roybal, and Mr. Leland have stated in terms of the needs of the elderly—particularly in relationship to the paradox that continues with overflowing granaries and excess cheese and the inability to distribute these foodstuffs.

We all recognize that it is a challenge to meet the needs of the elderly, as well as the needs of poor children, whose numbers are growing. But, I would like to point out that because of Gramm-Rudman requirements there is a very real possibility of across-the-board budget cuts which do not take into account the merits of one program over another. Therefore, it is necessary for the House of Representatives to come up with an alternative budget in order to avoid these across-the-board cuts.

The nutritional programs for the elderly are not exempted under Gramm-Rudman the way some other programs are, such as the Food Stamp Program and Social Security, and other programs that directly affect the well-being of our elderly.

So we on these committees should certainly exercise every effort to see to it that the budget committees come up with an alternative budget that not only is a political document, but that can get bipartisan support and avoid the across-the-board devastation of Gramm-Rudman in September.

Thank you very much.

[The prepared statement of Mrs. Roukema appears at the conclusion of the hearing, see p. 53.]

Mr. PANETTA. Mr. Hertel.

OPENING STATEMENT OF HON. DENNIS M. HERTEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. HERTEL. Well, I just want to commend the chairman here, all three of the cochairmen, for the hard work they've been doing, especially in how they're involved in meeting the needs of what was just mentioned by the last speaker, and that is by making sure that these things don't take place in any way, shape, or form.

I know all the members here are committed today, and I look forward to hearing all the testimony this afternoon about not only the needs, but about some of the projects and programs that have worked so well.

Mr. Panetta, again, has done very much in innovation in that very area.

Last night the evening news stated that even some of the programs that we do have, that are funded that do exist are not being used by our senior citizens because of the fear of embarrassment, of being ostracized, and the fact that they worked so very hard in their life and sacrificed for the rest of us. I think we have to look at new approaches as much as possible.

People that are retired today have done more for this country than any other generation. They have fought two World Wars at home and abroad; they lived through the world's worst Depression; they lived through the highest increase in taxation in this country's history. Throughout all of that they were able to maintain the values of this country, to work hard for this country, and teach other generations that this country can be a better place in each succeeding generation.

They taught us basically the importance of family. Now I think it's important that we remember those sacrifices, and make sure that these people are going to have the fullest measure of dignity with programs we make, to assure them a better life, a reward in dignity for all that they've done for the rest of us.

Mr. PANETTA. Mr. Lightfoot.

OPENING STATEMENT OF HON. JIM LIGHTFOOT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. LIGHTFOOT. Thank you, Mr. Chairman. In the interest of time I'll just ask to put my opening statement in the record. I represent the 27th elderly district in the Nation.

All the programs, without exception, are very effective. Thank you, Mr. Panetta, and Mr. Leland.

Mr. PANETTA. Without objection, your statement will be made a part of the record.

[The prepared statement of Mr. Lightfoot appears at the conclusion of the hearing, see p. 55.]

Mr. PANETTA. Mr. Schuette.

OPENING STATEMENT OF HON. BILL SCHUETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. SCHUETTE. Thank you. In the interest of time, let me make my comments brief.

Let me congratulate the trio of chairmen for organizing this, and say that the district I represent in Michigan, a rural district, prob-

lems of the rural elderly are a great concern to me. Initiatives like Meals on Wheels have proven to be very effective, so that's why I'm so interested in being here today, and the testimony I'm sure will help these respective committees in the deliberations we have to make.

Thank you, Mr. Chairman.

Mr. PANETTA. Mr. Ridge.

OPENING STATEMENT OF HON. THOMAS J. RIDGE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. RIDGE. Thank you, Mr. Chairman. And, likewise, I would like the record to reflect my appreciation for this joint hearing, and my reluctance to leave at this juncture to go to the Banking Committee markup for several pieces of legislation is pretty clear. I guess the evidence is reputable that there's a nexus between poverty among senior citizens, and the adequacy of their nutrition. And, again, I am grateful to all three chairmen for this initiative in this joint hearing, and look forward at a later time to reviewing the testimony of witnesses all in support of this effort.

Mr. PANETTA. Thank you. For the information of the committee, as you know, we've got a vote on. This is a vote on the roll and the supplemental, if I'm not mistaken. And what I'd like to do is to have Mr. Hutton and Mr. Driggs take their place, and we will adjourn briefly to go vote, and try to return as quickly as we can.

[Recess.]

Mr. PANETTA. This joint hearing on the hunger problems of the elderly is now reconvened.

I'd like to introduce Mr. William Hutton, who everyone knows, is the executive director of the National Council of Senior Citizens. He represents about 4.5 million seniors who participate in the State and local councils of the seniors citizens providing an overview of the trends of the elderly population, and the extent to which food assistance programs are meeting the needs of the low income elderly.

I think also it would be appropriate at this time to have Mr. McCain introduce Mr. Driggs.

OPENING STATEMENT OF HON. JOHN McCAIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. MCCAIN. Thank you, Mr. Chairman. I appreciate you and the other chairmen having this very important hearing today. I also would like to take particular pleasure in noticing the presence of Mr. John Driggs, whose testimony concerns the problem here, hunger amongst our senior citizens.

His testimony is only the latest deed in a lifetime of public service. Mr. Driggs is a graduate of North Phoenix High School in Arizona. He earned an A.B. and an M.B.A. at Stanford University. Mayor of Phoenix, AZ, from 1970 until 1974. John Driggs has been a member of two Presidental commissions, including the President's Task Force on Assistance.

Mr. Driggs is currently the chairman of Western Savings and Loan in Phoenix; not satisfied to rest on previous good works, he also serves as chairman of the board of Second Harvest Food Bank.

Mr. Driggs has now begun a campaign to helping hunger by informing America's hungry of food stamp benefits which he will describe to us today in his testimony.

He doesn't work for acclamation. His altruism has earned him numerous awards, including Phoenix Man of the Year. I believe, Mr. Chairman, he is the best of Arizona, beloved father and husband, and successful career man and a selfless citizen.

I appreciate very much his presence here today, and I believe his testimony will add a great deal to our ability to facilitate private and public sector cooperation in efforts addressing the serious problem of hunger which you have so eloquently articulated in opening statements.

Thank you, Mr. Chairman.

Mr. PANETTA. Thank you, and we welcome you, Mr. Driggs.

Mr. Hutton, you may proceed. Your statement will be made part of the record, and you can either read or summarize it as you wish.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY EDITH KASSNER, SENIOR RESEARCH ASSISTANT

Mr. HUTTON. Thank you. If I may, Mr. Chairman, I'd like to have you accept the testimony I have submitted for the record.

Mr. PANETTA. Without objection, your statement will be made part of the record.

Mr. HUTTON. I am glad that the Select Committees on Hunger and Aging have joined forces to examine the problems of hunger among the elderly. There has been very little attention devoted to this issue recently, although hunger and malnutrition afflict many older persons and poor nutrition can adversely affect health maintenance.

The first question the National Council would ask is "Why is there hunger among the elderly?"

Most Americans who experience hunger or malnutrition do so for purely economic reasons. The causes are far more complex among the elderly population. Among factors which may contribute to poor nutrition among the aged are: Chronic illness, diminished ability to absorb nutrients through food, loneliness, which is common among the elderly, and difficulty in shopping for food, and preparing meals. Lack of income will exacerbate these problem, therefore, must be given special attention.

The development of the poverty line based upon a diet plan designed only for a short-term use. Then a lower poverty standard was established for the elderly based on the assumption that older people need less food than do younger persons.

But while the elderly require fewer calories, their nutritional needs do not diminish. An income 25 percent above the official poverty line has been recommended to provide a nutritional by adequate diet for the elderly.

Using that standard, we have 5.7 million persons aged 65 and over who may be at nutritionally risk. This constitutes 21 percent of the Nation's elderly. Certain subgroups of the elderly are far more likely to be poor and consequently risk hunger: Women, mi-

norities, persons living alone, and the very old. And more and more people are falling into these groups in America.

What programs exist to address these needs? Despite Federal programs designed to address the economic and nutritional needs of the elderly, serious gaps exist in the so-called social safety net.

By far, the most successful antipoverty program for the elderly is Social Security. Improved adequacy and regular indexation of benefits instituted during the 1970's are almost singlehandedly responsible for the dramatic reduction in poverty among the aged.

But lower income elders are enormously dependent upon Social Security. Aged households with incomes under $5,000 receive 80 percent of their income from Social Security. Such households receive only 11 percent of their income from public assistance programs. Social Security income prevents 9.4 million older persons from falling into poverty, and reduces the poverty rate for the aged from 47.8 to 12.4 percent. That's from the Ways and Means Committee green book. It's very clear for all to see.

Those older persons who do not escape poverty through Social Security payments may be aided by the Supplemental Security Income Program, but in most cases SSI does not prevent poverty because Federal payment is set at 75 percent of the poverty line for individuals, 90 percent for couples.

Furthermore, only about one-third of the elderly receive SSI. That's because so many people still don't know about it.

While many States supplement the Federal payment, almost none bring recipients over the poverty line. Even when maximum SSI benefits are added to food stamp benefits, only four States bring individuals out of poverty. Nationally, the Federal SSI benefit for individuals combined with Social Security and food stamps amounts to just 84 percent of the poverty line.

Disturbing as these figures are, they may present an overly optimistic picture, for in addition to low participation in SSI, fewer than one third of poor families containing an elderly member receive food stamp benefits. Only 15 percent of elderly families in poverty receive Social Security, SSI, and food stamps. That's getting all three.

The two programs specifically designed to meet the nutritional needs of the elderly, are congregate and home delivered meals. Funding levels for these programs are woefully inadequate.

In 1984 more than 7 million persons 60 years and older live below 125 percent of the poverty line, yet only 2 million senior citizens of greatest economic need were served by either congregate or home delivered meal programs in fiscal year 1985.

Despite the congressional mandate to target services to the poor, the ability of service providers to accomplish this goal has diminished over the past 5 years. Whereas, in 1982, 61 percent of the congregate meal participants were economically needy, that proportion had dropped to 53 percent in 1985.

There's been considerable concern among service providers that the drop in low income participation is linked to strenuous efforts by the administration to collect more voluntary contributions from the program participants.

When the regulations to the Older Americans Act were overhauled last year, the requirement that all service providers assist

participants in taking advantage of benefits available to them under the Food Stamp Program was deleted. Although more than half the participants in senior meal programs are poor, only 13 percent of congregate meals participants, and 19 percent of home delivered meals participants, received food stamps.

Our recommendations are simply these, in the testimony I've submitted, there clearly needs to be more public education directed to the low-income elderly informing them of Federal programs for which they may be eligible. An important first step was taken during reauthorization of the Food Stamp Program last year when Congress directed Social Security offices to provide beneficiaries with information about food stamps, and to assist SSI participants in applying for benefits.

Such efforts must be expanded. Social Security offices are familiar to, and utilized by virtually all older persons. As such, they should expand efforts to notify persons with small Social Security benefits of the availability of SSI and food stamp benefits. They should be far more active in assisting such persons in applying for benefits.

The other currently existing structure with which many older persons are comfortable and familiar is that of the Older Americans Act programs. The National Council of Senior Citizens strongly recommends that new funding be allocated specifically to help the Older Americans Act service providers to inform and assist participants with food stamp information.

We also believe additional funds are needed to expand meal services to currently unserved low income elderly persons. In our view, it's not cost-effective to cut corners on nutrition programs which can help preserve the health of our Nation's older citizens.

Finally, the nutritional needs of the elderly would be addressed by raising Federal SSI benefits at least to the poverty line. It is very difficult to insure nutritional adequacy for persons whose incomes are obviously insufficient.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hutton appears at the conclusion of the hearing, see p. 64.]

Mr. PANETTA. Thank you very much, Mr. Hutton.

Mr. Driggs, you may proceed.

STATEMENT OF JOHN DRIGGS, CHAIRMAN, WESTERN SAVINGS AND LOAN, PHOENIX, AZ

Mr. DRIGGS. Mr. Chairman, members of the select committees, it's a privilege for me to have this opportunity to testify. I do not have a prepared text inasmuch as I was invited to attend this hearing yesterday afternoon, but I will quickly review the issues I think that perhaps caused my invitation, and that is the recently inaugurated program of the Advertising Council of a Food Stamp Information Program.

I had the privilege of serving on President Reagan's Task Force on Food Assistance over 2 years ago, and I recall that on August 3, 1983, when the task force was announced, there were two things that struck me in that article.

One, the President said it would be a national tragedy if an elderly person went to bed hungry at night, or a child.

He also said in the same letter, it may be that people are unaware of the Federal programs designed to help them.

My task force experience was interesting. I think the task force brought certain things to light. I was concerned when it concluded, however, that there was still something else out there. I was concerned, and I said it on the last day, I felt the problem was access to the program.

Finally, a couple of months later the idea finally came to me through some inquiry that since the issue of nonparticipation by those eligible for the program, that percentage which is estimated between one-third and 40 percent, at least to that extent the program was not effective. And the President had asked us to examine the Food Stamp Program and others to determine how they could more effectively meet the needs of low-income persons, because eligible people are not participating, then it's 100 percent ineffective.

Studies also showed that most of the reasons for nonparticipation related to informational aspects. That, coupled with pride and stigma which seemed to be very apparent through our testimonies and hearings, of a concern of the elderly. I wondered what Madison Avenue might do about a communication problem. And I ultimately ended up at the Ad Council, and asked them if they would do a nationwide public service information campaign on food stamp eligibility.

That process of gaining Ad Council approval took about 9 months. It involved ultimately after tentative approval the assignment of a New York Volunteer Advertising Agency, which did considerable research to try to get at some of the attitudes about the Food Stamp Program. It took about a year to organize all of the material for this national awareness program. I'm happy to say that it was announced early in February the—all of the advertising material in all media has been running now for about 2 months. And I remember the head of the Ad Council Committee, asked the ad agency, what are you going to do with this program if the phones don't ring?

Well, I can tell you, members of the committees, that the phones have been ringing. They are ringing at the rate of about 1,000 a day.

On March 19 I had the privilege of being asked to be on the "Today Show" in New York. They ran the commercial, the 30-second commercial. That day we had 10,000 telephone calls to a national answering service that had been set up, and that was just in the first 5 hours. The answering service said that they might have taken 50 percent more, but that the lines would ring busy.

So it is working. The whole thrust of this Ad Council campaign is to make people aware of the program in the event that they may qualify. It invites people to call a national toll free line. When they do that two things happen. They are asked for their name and address, if they would like to receive a free brochure outlining detailed food stamp eligibility information. And that is sent to them in an envelope, first-class mail, within a week to 10 days.

They are also given the number of their State toll free food stamp hotline if one exists, and it exists in about 80 percent of the

States. In the other States we have given them an optional number. It may not be toll free. It differs among the States.

But for the first time perhaps in the history of the Food Stamp Program we have a national communication network that can provide information about the program, and also give them more detailed reference to local information.

The response I think speaks for itself. This is a private sector effort, which is designed to help a Federal program. I might tell you that all of the costs, the hard costs involved in this, have been raised from private individuals, and primarily corporations in this country. I've raised some $420,000 to date that has paid for all of the costs of producing the campaign, as well as manning the telephone answering system.

You have in your packets a copy of a poster which is designed to perhaps improve a bit the image of the Food Stamp Program. It says half the people suffering from unemployment aren't old enough to work. And, frankly, while the focus of this hearing is on elderly, I think that anyone who sees a child is going to be struck by this, and this kind of information awareness program may help to offset some of the stigma about the Food Stamp Program.

And I can tell you from my experiences in trying to put this Ad Council program together over the last 2 years, that hardly ever do I bring up the word food stamp when it turns people off. And then when I—they always bring up—conjure up the perceptions of fraud, waste, and abuse, and when they asked about that, I said, one thing we're going to try to do is make the public understand better what the Food Stamp Program is designed to do. And when people can read this brochure, and understand the eligibility criteria, perhaps their attitude about the program will improve also.

We know from studies that some 8 to 10 million eligible but nonparticipating persons in the Food Stamp Program that was studied by Richard Coe out of the Michigan Panel of Income Dynamics, the statistics showed that 49 percent of this eligible nonparticipating group are in the elderly category, and 34.5 percent are elderly female living alone. And of the some 10 million, 40 percent receive no AFDC, SSI, or even Social Security.

The participation rate is lower among elderly. If it's 60 percent of the general population, it may be only 50 percent among elderly.

About the same number of people participated in the Food Stamp Program last year as did in 1980, and yet the poverty population has increased by some 4 million.

I would like to mention one concern, and perhaps plant a seed. This is the first opportunity I've had to visit a congressional committee about this effort.

I know that my job over the next year is to make sure we have enough money to keep printing the brochures. Incidentally, we have had—while we've had some 40,000 telephone calls, we have had requests for this brochure from State agencies and community groups throughout the country of some 700,000. We are already into our second half million printing. I've been able to raise enough money to keep ahead of the game. And also to keep answering the telephone. At some point in the future, based on some review of this program as it commences, we may need to approach the Congress to see if there will be some mechanism to keep somebody

there to answer the telephone so that when people call to inquire for food stamp information that there is somebody there to answer the phone.

But I think what we are developing for you will be a very interesting set of statistics over the next couple of years that this Ad Council program will run at a minimum. Then the Ad Council will ask if it's good, and if you want to renew it, and then use the great multiplier effect of the Ad Council where at this point a half million dollars of private sector funds are going to have a multiplier effect, and do sort of an unusual match of over the next 2 years of producing roughly $150 to $170 million worth of information through the private sector media.

It's a privilege——

Mr. PANETTA. I apologize for interrupting, but—we'll be back with questions, but I aplogize to both of you. We have to vote on another roll. And we'll try to get back in 5 minutes.

[Recess.]

Mr. Panetta. The select committee hearing is now reconvened.

We just heard the testimony of Mr. Hutton and Mr. Driggs.

Mr. Driggs, you were adding an additional statement. Go ahead.

Mr. DRIGGS. Yes, Mr. Chairman. If I could just appreciate this opportunity, and I would like to insert into the record a copy of the television commercials that are now running which apparently are causing the greatest response, as well as the pamphlet, the information brochure, that is being sent out in response to inquiries.

I appreciate very much this opportunity to describe this public information program.

[The information referred to above retained in committee files.]

RESPONSES TO QUESTIONS FOR JOHN DRIGGS

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. How has the discontinuation of federally funded Food Stamp Program information activities since 1981 affected participation?

Answer. There are no studies of how the discontinuation affected participation. There have been studies on nonparticipation concluding the lack of information on the Food Stamp Program is one of the principle factors affecting participation.

Question. What key legislative recommendations of the President's Task Force on Food Assistance have not yet been implemented?

Answer. (a) The recommendation to make food assistance programs optional for States was rejected by Congress.

(b) The asset limits modification have been only partially implemented.

(c) The cash-out recommendation for elderly and Social Security Insurance recipients has not been implemented.

(d) The requirement for States to be fully responsible for overpayment errors in excess of 5 percent has not been implemented.

(e) The recommendation to restrict eligibility for child care home subsidies to homes in low-income areas has not been implemented.

(f) The recommendation to reauthorize WIC Program at current caseload is pending in H.R. 7.

(g) The recommendation that the Federal Government take steps to improve information on nutrition status has passed the House and is pending in the Senate.

(h) There has been no action on the recommendation that the Federal Government lead a cooperative effort between Federal, State, and local governments and the private sector in addressing the problems of the homeless.

(i) The recommendation to increase distribution of existing commodities probably has not been implemented.

Question. Please explain your interest in a food stamp credit card system and how this would improve program participation for those who are eligible but not currently participating?

Answer. A food stamp credit card system may hold promise. It has been tested in Reading, PA with indications of certain advantages and disadvantages. It would be expensive to implement. It has the potential of eliminating the stigma factor. There would be complex system problems. It would appear to be a good idea, except for the cost factor. It needs additional study, but may be the wave of the future in 10 to 15 years.

Mr. PANETTA. Thank you very much.

Mr. Hutton, in your testimony you used the—you make the statement that nearly 5.7 million persons aged 65 and over may be at nutritional risk, and that would constitute about 21 percent of the Nation's elderly.

Where does that figure come from? What is the basis for that?

Mr. HUTTON. The Census Bureau. That's where we got it from.

I introduce Ms. Enid Kassner, who is the research assistant in charge of our hunger and nutritional programs, and she tells me that's where it came from.

Mr. PANETTA. When you say nutritional risk, how do you define that?

Mr. HUTTON. How do you define nutritional risk?

Ms. KASSNER. The figure is based on persons falling below 125 percent of the poverty line, and as Robert Butler, who is one of the foremost experts in nutrition and the elderly has stated in the past, for elderly peoples an income 25 percent over the official poverty line is recommended to guarantee nutritional adequacy. So we believe that people who fall below that income level are at risk of inadequate nutrition.

Mr. PANETTA. I take it you share the attitude that the money that is spent on the nutrition programs, saves money in the long run in terms of health care costs?

Mr. HUTTON. Yes, sir, most surely.

Mr. PANETTA. And that that's pretty much substantiated by your experience?

Mr. HUTTON. And the experience of most of our elderly people who have to pay much more for their health treatment, which has obviously resulted in many cases from inadequate assistance in eating correctly.

Mr. PANETTA. The one figure that I used in Detroit, which I just was astounded by—of course, they have a great operation in terms of the distribution of that commodity—they have something like 16,000 people in the waiting line, waiting list, to be able to receive those commodities and all of them are elderly.

Is that something you're running into in other parts of the country?

Mr. HUTTON. Across the country. I was just down in Texas last week, in an area in which I didn't expect that to happen. It's very severe in places like Port Arthur, and Beaumont, TX, and particularly in the rural areas. They're having a hard time down there.

Mr. PANETTA. Mr. Driggs, why with all of the attention in the debate on Food Stamp Program that's going on over the last 10, 12 years, as well as the other programs, why is it that so few of the elderly want to participate in this program, or is it awareness, is it

other factors? What's the main reason that there is this lack of participation in the program?

Mr. DRIGGS. Mr. Chairman, I believe that it really fit into two categories. One study out of the mathematical policy research under contract with USDA recently focused on why elderly persons do not participate. They found that 33 percent of the eligible elderly who were not in the program mistakenly believed they were ineligible, while another 36 percent did not know whether they were eligible.

So you have approximately 70 percent of the nonparticipating elderly either thought they were ineligible, or didn't know if they were eligible.

And then the pride stigma effect, I know just from personal experience and observation, is very important in this. And the extent to which any information program can improve the image of the program, I think would have a sagatory benefit there also.

Mr. PANETTA. When you get something like 10,000 calls that come in, do you have any idea of the 10,000 how many, in fact, later are able to receive those benefits?

Let me make the question broader. The outreach that you've had with regard to people, how many ultimately get onto the program? Do you know what the percentages are?

Mr. DRIGGS. Mr. Chairman, since this has been running just a few weeks we do not have an adequate data base to do that, but I have told certain staff members of your committees that we will be compiling a lot of good research data. We'll be able to identify the location of every telephone call . And perhaps after a year's experience, we will know—we'll be able to take samples, valid statistical samples, and go back and trace certain names, calls, areas, whether they were actually qualified and did enter the program.

So I think there will be out of this Ad Council program some very good statistical raw material.

Mr. PANETTA. Mr. Hutton, did you have something to add?

Mr. HUTTON. Yes. I would like to add just in that area, Mr. Chairman, food stamps have only been with us, as a national program, since 1974, and yet this is the first time through this Ad Council that we've had a program appealing to people. It has been a case of chronic neglect in trying to get out this information over many years. I'm grateful for the effort which has been made now. I hope it can be expanded in other directions. I hope it will be expanded into making TV public statements, and radio statements.

We now need a bigger effort than this if we're going to correct the errors of 12 years.

Mr. PANETTA. When I first joined the Subcommittee on Nutrition, on the Agriculture Committee, we had an outreach program on food stamps. It was targeted at that time for cuts because there was concern about why we were advertising the program to people in need. Thus, it was eliminated.

We began, as you stated in your testimony, to take a step back in the direction of trying to get some kind of outreach out to seniors. I am really very pleased with this program because it's a very positive kind of advertisement campaign. And I think you're right, I think it's not only the ignorance of it. It's those that hesitate to get on the program for lack of knowledge of what it's about, and also

because they're not—they always hear about the stories of food stamp abuse, and to some extent it carries that kind of image. This helps to convey the image of just exactly how the program can work for their needs.

What's the amount, Mr. Driggs, that you're now spending on this campaign?

Mr. DRIGGS. I've—one $50,000 contribution will be confirmed next Tuesday. If that comes through, I will have raised $419,000, most all of which has been spent up-to-date. And I will just have to keep raising some money so that this telephone answering service will be able to respond.

Mr. PANETTA. What are your plans for the future?

Mr. DRIGGS. Well, just to keep raising the money. And as I mentioned, at some point I think the private sector might run out of steam, and at that point perhaps we may in order to maintain something which may prove to be valuable, we may wish to address this here at the Congress at some future date.

Mr. PANETTA. OK. Well, thank you both very much.

Mr. Roybal.

Mr. ROYBAL. Thank you, Mr. Chairman.

Mr. Hutton, I'm somewhat concerned about the statement you made in your written testimony. You say that only 15 percent of elderly families in poverty receive Social Security, SSI, and food stamps.

Mr. HUTTON. That's all three, sir.

Mr. ROYBAL. That's for all three?

Mr. HUTTON. I added—that's all three. Only 15 percent receive all three of them.

Mr. ROYBAL. All three.

Can you please provide for the record the percentage that received Social Security, SSI, and also food stamps?

Mr. HUTTON. No; that's the figure, 15 percent. You want it on a separate basis?

Mr. ROYBAL. On a separate basis. Now, I'm sure——

Mr. HUTTON. We'll do that. I'll supply that. This is all three, but we know on food stamps—we know that they reach about one-third of the elderly poor. SSI reaches about one-third of the elderly poor.

Mr. ROYBAL. Only one-third of the elderly poor now receive SSI?

Mr. HUTTON. That's right.

Mr. ROYBAL. And is the same true with regard to food stamps?

Mr. HUTTON. The same is true with regard to food stamps. Only one third of those eligible receive it.

Mr. ROYBAL. Which means that two thirds of those that may be eligible do not receive either SSI or food stamps, but they may be receiving Social Security?

Mr. HUTTON. They may be receiving Social Security or SSI.

Mr. ROYBAL. You also said that low participation by the elderly in the SSI and Food Stamp Program has been often noted, but little has been done to address this problem.

What do you think can be done, or should be done, to address this problem?

Mr. HUTTON. Well, this is a great start, but it's a volunteer effort. The effort of producing this brochure, and the effort of joining with the Ad Council, and eliciting that generous organization

to help, is something. But it really is a drop in the bucket, a drop in the bucket to the years and years of chronic neglect in reaching the people who are entitled to the program but don't know about it.

It should have been a program in which financing was also provided by the Government for television time, bought announcements, radio time, and other ways to reach people.

When we first started the program of Medicare we couldn't get older people to answer the door if young people came around. We couldn't get them to answer the mail. But we started a major program which was financed by the Social Security Administration getting people to sign them up for Medicare. They were already on Social Security, but were not signing up, which they had to do. And over the course of a year we signed up something like 25 million older people into the Medicare Program. It cost a lot of money, but it was worth doing it. That's the kind of program that should have been put to work in connection with the food programs.

Mr. ROYBAL. Then one of the things that may work is perhaps a brochure such as the one described by Mr. Driggs.

If that were the case, who would make the brochure available? Since two-thirds do not participate in these two very important programs, how can that information be made more available?

Mr. HUTTON. One thing, I think that several thousand of these should be available in every Social Security office around the country. There are about 1,000 Social Security offices, so right there 1 million would be required for that. The church is another area. Buses. The Ad Council could put bus cards up in the buses about the Food Stamp Program. There is a little box where you can put brochures like this in there. I would have them in the buses and the subway.

Mr. ROYBAL. Mr. Hutton and Mr. Driggs, there is quite obviously a lack of communication and a lack of information being received by those who may be eligible for both SSI and food stamps. Do you think that organizations such as yours, as well as other organizations for senior citizens, might be interested in developing a coordinated network of information pamphlets which could list specific programs available through the Federal Government?

In other words, do you think that the senior citizen organizations in this country can start a program that will ultimately result in informing more people of their rights?

Mr. HUTTON. The ones who are wealthy could. The others—for example, the Congress has just hit us with a $240,000 increase in postage for our newspaper. It would severely curtail our newspaper. It can't get to the people.

That is one of the little things.

Mr. ROYBAL. I'm chairman of the committee that handled that item, and I can assure you that we're going to look at it very carefully.

Mr. HUTTON. Thank you very much, Mr. Chairman.

Mr. ROYBAL. I don't know what the Congress will do, but I think the recommendation made by the President should not prevail. I think revenue foregone is something that should continue to be subsidized, and that the problem you just described is not a problem for any particular organization.

In the event we're successful in restoring that expenditure, do you think it is possible for these organizations to come to some understanding and start a program such as the one that we have described?

Mr. HUTTON. Yes, it is, Mr. Chairman. We've already worked on similar type things, and with a certain amount of encouragement, and if we could get some help, we can do it—we funded a Project Energy Care, for example, to help sign people up for low-income energy assistance.

Mr. ROYBAL. Mr. Driggs, do you have anything you can add to that? Is there a possibility that something can be done?

We know that the present system has failed. What can we do to improve the situation?

Mr. DRIGGS. Mr. Chairman, I think you struck on it in putting this particular project together. To have some credibility when I went to the Ad Council, I literally organized the kinds of groups that you talked about. We got the support of the National Governors' Association, and the National Association of Counties, Conference of Mayors, League of Cities, American Public Welfare, Salvation Army, Catholic Charities, United Way, the National Council of Churches, many organizations already.

For instance, the Salvation Army now has in its hands in the 42 major locations in the country 86,000 of these brochures.

The American Association of Retired Persons has just ordered an initial quantity of 10,000.

So this networking that you talk about is not only feasible, it actually is beginning to work as far as this particular piece is concerned. So I think we're just on the cutting edge of implementing the kind of thing you're talking about.

Mr. PANETTA. Thank you very much. The Chair recognizes Mr. McCain.

Mr. MCCAIN. Thank you, Mr. Chairman. And thank you, Mr. Hutton, for your very important testimony today.

I really think you achieved something rather remarkable. I'm sure, when you embarked on this project they told you it could not be done.

Have you found that this lack of knowledge concerning the availability of these programs is uniform throughout the country, or is it certain parts of the country that there is less knowledge on availability?

Mr. DRIGGS. This is interesting. We know from studies about nonparticipation that the problem of nonparticipation of those eligible is greatest in the South significantly, and there again, communication, information, it is not—it's a moderate problem in the Northeast and Midwest, less of a problem in the West.

However, we're finding that the telephone calls now in response to the public service announcements seem to be coming somewhat uniformly across the country, but it is early to judge because these spots run at the whim of the media as to whenever they want to run it, but we'll be able to tell after a 6-month period to a year, and match response to the availability of the information. And I think that will be of some use to congressional committees.

Mr. MCCAIN. I'd just like to follow up a little bit on what Chairman Roybal talked about. What more can we do to encourage pri-

vate sector involvement? What more can the Congress do? And what more can the agencies themselves do, and agencies such as represented by Mr. Hutton?

Mr. DRIGGS. Well, I think that the very fact that the Ad Council took on this project, it is somewhat unique. If you examine what the Ad Council has projected in the 40 years of their existence, they have rarely, if ever, taken on a social welfare related issue like the Food Stamp Program. A lot of people just didn't think they would do it.

But it is having good response. The Ad Council seems to be getting a lot of good attention by the fact that they have taken this on. So that personifies—the Ad Council personifies private sector participation.

So I think we can learn a good deal from what is happening with this particular project, and it may be that these kinds of things can be further translated into other areas. So it will work.

Mr. MCCAIN. Thank you very much, Mr. Chairman.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. Just two quick points.

Mr. Driggs, you mentioned in your testimony about the pride factor, that this kept some people from asking for food stamps, and so on. We foresee that to be something that predominates in our part of the country, in the Midwest.

A good example, we put together a care and share project designed to put food into the food pantries, which was no age limit for it. We discovered there were a number of elderly people who were benefiting from that, and one lady in particular who was brought to our office. To see her on the street you'd have no indication that she had any kind of a problem at all. But her husband had passed away, and her tradition she'd paid all of her bills. As a result, she was left with basically no money. Her home was neat, clean. She was neat and clean. But when we went to her house we found she had one blanket that she hung in the doorway during the daytime and covered up with it at night. And was a matter of pride that she had not gone to someone and asked for help.

Do you think that the way these ads are put together that they will appeal to that sense of pride, that will get people who may otherwise, for whatever reason, basic pride, would not come and ask for food stamps, and so on, they will do that? Do you think you've found a key in your advertising?

Mr. DRIGGS. Yes. The ad agency was very concerned about that. No. 1, we knew that we could never have sold the Ad Council on doing this project to combat pride and stigma. That's too indirect. But they very carefully cast the program, and the way they put all of the ads, and the pamphlet, and everything together, to get at this issue of negative public perception of the program because that is what causes this pride, stigma. It's an attempt to, in effect, say to people, look, if you're suffering from hard times, you've paid your dues, you've paid your taxes. No one should be ashamed of taking advantage of a specific Federal program at a time when they're suffering from that criteria.

So, those who have seen the television commercial believe that the advertising experts carefully have done this. Not only saying, look, if you need information, get it, but they've done it in a way that over time we'll combat the pride stigma issue by improving

general public perception and appreciation of the Food Stamp Program.

Mr. LIGHTFOOT. You mentioned you'd raised almost a half million dollars—$190,000—and you're concerned with continuing financing enough money to keep the phone bank going.

Do you have an estimate of what that might cost?

Mr. DRIGGS. Well, the telephone cost now runs—it's $1.20, 5 cents for a label, 15, 20 cents for an envelope, and it goes out first-class mail. We're getting up close to about $1.50, $1.40, $1.45, to process and get this piece of information in the hands of a person who calls.

So if we're running at the rate of 1,000 calls a day, we may get 350,000 calls in a year, that might affect with households, maybe you're reaching 1 million people. And you would reach them for $300,000 or $400,000, a little more than that.

So we're not talking about a great deal. Private corporations at this point have come up with this amount of money, and I'm sure that they'll respond up to the ability of someone asking them. At some point that may just realistically run out of steam and for an ongoing program this is something that we needed to look at.

Mr. LIGHTFOOT. I want to applaud you for doing this. I think it's an excellent approach. I think I've got a little bias here, but I personally think that probably as long as you raise private money and use it, you'll get a lot more bang for the buck than if you get Federal money involved in it because we tend to—it will probably cost us $6 for what you're doing for $1.50, if history bears fruit.

So I would encourage you to continue with that, and probably the American people, I think, would support it, as they realize the need is there, and that you're doing something.

I want to compliment both of you on the work you have done. Thank you.

Mrs. Bentley.

Mrs. BENTLEY. Thank you, Mr. Chairman. Mr. Chairman, before I begin with my questions, I would like to point out the first panelist, Senator Roselle Abrams from the State of Maryland, is doing an outstanding job as a State senator, and as director of the Maryland State Office of Aging.

I also want to commend Mr. Hutton and Mr. Driggs for what they are doing in their efforts in advertising on behalf of elderly people.

Yesterday I had a hearing on aging in my district, and one of the suggestions made, was that the rules be changed so that we could have an HMO—Health Maintenance Organization—just for the elderly, which would help where the HMO could devote its efforts to nutrition and the things that the elderly need, rather than having them spread their talent and staff out among all ages. That would be better. Do you have any opinion on that at all?

Mr. HUTTON. I heard it discussed before, Ms. Bentley, and the issues raised against it were just strictly that, in fact, the elderly people need three times more hospitalization than do people who are younger, and that consequently, it's a much more expensive operation than one which is mixed to carry young, middle aged, and elderly. You're spreading the risk through a lot more people. You

have a great deal of risk if you're only using the elderly people who have such heavy, and sometimes longer, incidences of illness.

But there's nothing wrong with it, to my mind. I think it's a very good—I think the saving would be there in terms of specialists in geriatic medicine; in terms of the availability of the right kind of drug medicine to advise for older people; the right kind of exercises. All this would be improved if our doctors knew more about the health care for older people, but they don't. And perhaps an HMO, which specifically does that, would be a good idea.

It's certainly worth trying in a major center, for example, in the city like Baltimore. To have at least one, to try it out there, and several cities throughout the country, would be a good idea.

Mrs. BENTLEY. Do it as a pilot program.

You speak about the lack of targeting of nutrition services for the past several years. With the reauthorization of these programs coming in the future, what changes would you make in title III so that nutrition services would be getting to those in need?

Mr. HUTTON. For myself, I'd like to pass that one to Ms. Kassner, but one thing I would like to mention—we've had a great deal of assistance in putting these things in Social Security offices. I'm frightened by the administration's aim to cut out 700 Social Security offices across the country. I think that would be devastating to older people, and certainly would limit, restrict the transferrance of information like this.

I think about many older people, for example, whose Social Security is even now hit by machines that break down, incorrect additions in their Social Security payments, what are they going to do to get those things corrected, and how long it takes to get them corrected, is fantastic. And to cut out those offices would be scandalous at this time when the age of older people is increasing, and where we're having many more older people to deal with.

Mrs. BENTLEY. Thank you.

Ms. KASSNER. With regard specifically to the congregate and home delivered meals programs, one of the problems is that when these programs are already serving to capacity, and have waiting lists, there is no way that they can add more low-income people to the programs.

We certainly recognize the need for these programs to serve all older people because there are people who are not absolutely at the poverty line who also benefit very greatly from both congregate meals and home delivery of meals.

In addition, the home delivered meals program is being put under incredible stress right now with the institution of the diagnostic-related groups system. For more people, there is considerable evidence of leaving the hospital with greater need for inhome services, and meals, of course, are a very important component of that service. If there is not funding allocated for those programs, we're going to see the people going back into the hospital when they cannot maintain themselves in the home.

So it really is not cost-effective not to provide additional funds for these meal programs.

Mrs. BENTLEY. Thank you.

Mr. PANETTA. Thank you, Mrs. Bentley, and thanks to both of you, and particularly I want to thank the National Council of

Senior Citizens for the help that was given to us in the food stamp bill last year, and food security bill. With your help I think we were able to accomplish some of the benefit changes that are working now.

Mr. HUTTON. Thank you, Chairman Panetta and Chairman Roybal.

Mr. PANETTA. The next panel is Adelaide Carpenter, and Dr. Lipschitz, David Lipschitz.

Ms. Adelaide Carpenter is from, I think, Mr. Lightfoot's area, and I would like to call on Mr. Lightfoot for her introduction.

Mr. LIGHTFOOT. Thank you, Mr. Chairman.

To the members of the Aging and Hungry Committees, at this time I'd like to welcome Adelaide Carpenter from Coon Rapids, IA. Adelaide is here today to tell us about her experience with the Polk County elderly feeding project.

Adelaide has a long record of voluntary service. In fact, starting back in 1966 she has shared her enthusiasm, her time, and her energy with others who have been less fortunate. She has been a Vista volunteer in New York, and in her home State of Iowa, and an RSVP volunteer in Des Moines, IA. Most recently she has been a volunteer for the Commodity Supplemental Food Program.

Besides delivering needed commodities to senior citizens, Adelaide also provides them with companionship. When you have an opportunity to meet her you'll understand that to many of them this is one of the few contacts they have with other people, and look forward to it with great anticipation. In many cases, the time that Adelaide spends with them visiting means almost as much as the food that she delivers.

With that, I introduce to you Adelaide Carpenter, someone who we all admire for her work on behalf of the low income elderly. Thank you, Adelaide.

Ms. CARPENTER. Thank you very much.

Mr. PANETTA. Thank you very much. Ms. Carpenter, if you could just wait a second, we're going to introduce Dr. Lipschitz, and we'll have you both give your testimony and do questions.

Dr. David Lipschitz is director of the Geriatic Research Education Clinical Center at the John McClellan Memorial VA Hospital in Little Rock, AR, and, incidentally, I think Congressman Hammerschmidt wanted to be here to welcome you, Doctor, from Arkansas, but is currently participating in another congressional hearing.

He's also—Dr. Lipschitz is also head of the division on aging at the University of Arkansas for Medical Sciences, and sits on many State and National geriatic research committees. He will testify on the health consequences of hunger among the elderly from the perspective of his own practice, research, and scientific literature.

Ms. Carpenter, if you would proceed now with your testimony.

STATEMENT OF ADELAIDE CARPENTER, VOLUNTEER, POLK COUNTY ELDERLY FEEDING PROGRAM, DES MOINES, IA

Ms. CARPENTER. Chairman Panetta, Chairman Roybal, and members of the committee. Thank you for allowing me to come and have this opportunity to talk to you about the Elderly Food Com-

modity Program. I hope you all can hear me. Since I came this far I want you to hear what I have to say.

I have been working with the elderly food project since it started in 1982. I went to work with this project because I heard the director speak to a legislative advocacy group that I belonged to, and I tell you, these places need good communication. She talked to a group of about 40 people, and many of us were interested in helping with the project that she described know that Des Moines, IA, was full of elderly people who were hungry.

And so at that time I agreed to come and work at anything except sitting in an office shuffling papers. So, my first work with the commodity program was delivering the 46 pounds of commodities which consisted of dry, and canned food commodities, plus the butter and cheese, if it was needed.

And, I would like to take you all with me on some of my trips into the homes.

I came as a volunteer to give you a personal idea of what some of these places were like, and the people were like. I'd like to have you all just march with me and go back to Iowa with me, and travel some of the places I've been so you can really see for yourself. But since I can't do that, I'm going to try and describe some of my trips into the homes of the people who were really in need of food.

Each of the places that I went to involved personal communication with the clients in the home. I sat at the table with them, I looked into their eyes, and sometimes I saw the pain of those having to accept welfare. Indeed, many of them could not keep tears from their eyes as they described their hardships and struggles.

I know that some of these people are getting food stamps; others were getting Meals on Wheels, and oftentimes many of them were trying to save portions of that noon meal so that they might have something for the next meal, or for the weekend.

I would like to have you go with me on one of my first trips, and I'm sure you already know that I'm not going to stick tight to what's on this paper.

One of my first trips delivering commodities was to a very small cottage with peeling paint. It was on an unsurfaced street with no curb or gutter. It was my first stop of the day, and I had 46 pounds of commodities in two big boxes. Why? Because I couldn't carry 46 pounds in one trip by myself over the snow and the ice, which I had to go across.

After knocking hard at the door, and waiting for some time, Bessie, age 86, came to the door and she opened the door with one hand and hung onto her walker with the other. She was really happy to see me, and I should say that she is a person who is always called before anyone goes with the commodities, so she knew someone was coming.

She was real happy, and she smiled, and just thought it was great to have me come in not just because I had food, but because she knew I would stay and talk to her for a while.

After getting the two large boxes into her kitchen, I sat down across from her at her small kitchen table. She, of course, looked at everything as I went through the packages, which I always did so

they would understand what they were getting, and possible ways to use it if they didn't know how. And she asked "how do you use those dried eggs? I'm not sure about farina either. How do you use that?"

I answered her questions, and she wanted me to put things as I talked about them into her cupboard. And I really felt like old Mother Hubbard. I went to her cupboard and it was mostly bare. There was a bit of canned milk, and there were two cans of corn in this cupboard. As I put the things in her cupboard she kept talking to me about what she was going to do with them. So I listened to her problems, and I listened to her fears, and she watched me put them away.

Her $289 Social Security check wasn't allowing for anything other than the bare necessities. And without energy assistance, and help from the board of supervisors on her real estate taxes, along with the commodities, she couldn't have made it.

Go with me on another visit. I went to a second floor apartment above a long, long empty business place. Hannah, partially blind, called for me to come up when I pushed her buzzer at the bottom of the stairway, a cluttered, filthy place. She told me to come up. I did. The apartment that she was in was very, very tiny. It didn't have much furniture, but much stuff and junk piled on what there was.

She finally did get a chair cleared for me to sit on, and we talked about the commodities. They had to be kept on the floor because her kitchen was only an old clothes closet, and if any of you have been—I'm sure you remember some of your early homes, the closets were not very big. I helped her go through the packages because she was partially blind. I wanted her to feel them so that she would know the dried eggs from the instant potatoes. And that she would understand what was in each package that she was getting.

Can you imagine what the commodities meant to her?

On yet another delivery to a homebound, a 93-year-old lady, who answered—I should say 93-years-young really—she came to the door and first thing she said, because it was a cold snowy day, she said, "oh, I was afraid you wouldn't make it today." So I just said that the wind helped me along, and that I did have two boxes of goodies for her.

So after they were out on the kitchen table, she was anxious to look them over, and she chattered, "do you know what I'm going to eat tonight? That farina. I really like it, and if there are raisins, I'm going to put a handful of raisins in it." She went on. "I really like to cook my own meals because then I can eat what I really like."

And then she looked at the dried eggs, and she felt the bag, and she said, "at first I never thought I'd use that stuff, but I've learned they aren't so bad if you doctor them up a little bit." And then she did say, "but I really miss seeing the hens and hearing them."

I listened to her as I got all of the commodities I could on the shelves, and then she looked up and said, "please don't close the door. I want to look at them a while."

Would you like to look at your wives' cupboards and see them bare? Who can guess how Bessie felt.

Now go with me on a certification visit. And a certification visit is one the people have never had commodities, and they have to be certified by making out a lengthy legal-sized application, three sides of it need to be filled out.

I went to visit Lizzie. Lizzie knew for some time that other people were getting commodities because she lived in a low rent subsidized housing apartment, and the other people had said to her "Lizzie, you really qualify for the commodities. Why don't you apply?" And she just couldn't make up her mind that she should have welfare. It really hurt her because she had been a cook. She had been a cook in a great big place out at—in Colorado, and she loved cooking, and she had always made her living. She was now helping take care of a 60-some-year-old son, and, oh, she didn't want to do this. But she finally got to the place where she decided she had to do something. And so she at 87 walked the 2 miles down to the warehouse where the office is, and when she got there it was on one of those days when the parking lot was jammed, and the office was so full of people that there was no way that anyone on the staff could stop and explain to her the program and help her in any way.

And so the director of the program, who is a very conscientious, wonderful person, and a very good administrator, told her that they had someone they would send out the next day to help her make out an application at home.

So I went the next day to her place, and the first thing she asked me was "I want to know all the rules and regulations about the program because I don't want to do anything wrong."

So, I explained the makeup of the program, and by listening to her, and asking questions, I knew that she would more than qualify according to all the requirements of the program.

So I described all of the commodities that she would be getting if she was accepted, and she kept talking as I told her about this. And when I said fruit juice, she said, "oh, we haven't had any for months", meaning her son too. And peanut butter? She said, "that's way too expensive for us."

Her son, who was sitting in a chair at the side of the room, wasn't able to get around very well, but he sat and he listened, and when she said that about the fruit juice and peanut butter, his eyes just grew. And then he looked over at me and he said, "my mom's a real good cook if she just has something to cook with."

Their combined monthly income was below the level for one. So they both qualified, but because the program's quota was frozen, and everybody that they were serving was over—was willing to be over the number of the 4,200, I couldn't tell her that they would be getting the commodities. I had to say, "you will be put on a waiting list."

How do you think I felt? And how do you think she felt?

In some ways she was—she wasn't surprised because in one way it was going to give her a chance to really accept this fact that she was going to have a welfare, as she called it, the term that she used. And I told her she needed them, she deserved them, she should have them, she had paid taxes, she had done all of these things.

And so since the program was frozen, and we had 500 eligibles still on a waiting list, I don't know when she'll get on, but I hope she does. What can I do, and what can you do?

I can go on, and on, and on, and take you with me into homes that I'm sure would make your eyes open and your heart ache just a little bit. But, I am not going to do that. I'll be glad to answer questions later. But I believe seeing is believing.

As you can tell, I really am enthusiastic about the program. I've been in the homes. I've touched these people. And I have listened to them. And I have seen what the commodities can do. I have sat and talked over how they can cook with the cookbook that I take them. How they can cook and use all of the commodities that they have. That they can take their dry milk, they can fix it with water, and they can add a few drops of lemon juice and have a good whipped topping. I told them about the nutrition of the meals that they can make with these.

So I know that if you could go with me you'd probably feel the same as I do, but you can't do that. But I do hope that you will think about how you can do something for this elderly food project. Des Moines, IA, Detroit, and New Orleans have demonstrated the value of the program, and that the volunteer system does work. Now it's up to Congress.

I know, or I hope I know, that you will not disappoint me, and my many friends back in Iowa. Friends that I have made serving the program, and friends that need a helping hand.

Thank you. I'll be glad to answer any questions.

RESPONSES TO QUESTIONS FOR ADELAIDE CARPENTER

QUESTIONS SUBMITTED BY HON. LEON PANETTA

Question. Last week, Mr. Leard from the Office of Food and Nutrition Services at USDA testified that the Commodity Supplemental Food Program for the elderly is duplicative of other Federal nutrition programs. From your experience in the community, does CSFP provide food and nutrition assistance to a population that is not served by other elderly nutrition programs?

Answer. I firmly believe that CSFP has provided very unique food and nutritional assistance to the elderly. With the commodities received and the nutritional guidance given by the volunteers they can prepare their own meal—and just the way they like it. Most of the clients are not able to get out and take advantage of the other programs.

Question. Mr. Leard also indicated the Department is not supportive of expansion on CSFP for the elderly. We know that they have transferred $3.95 million out of the account and are working on legislation to bring that money back to CSFP for program expansion. What is USDA telling your program manager about the availability of funds to maintain or expand the caseload?

Answer. Wait—wait—until final decisions are made.

Question. Why do you believe that CSFP is a low-cost food assistance program for the Federal Government?

Answer. I know it is because of the assistance of the many volunteers—some 250 in Des Moines.

Question. Over the last 4 years as your program caseload has expanded, did you receive adequate funds for the administration of that expansion?

Answer. As a volunteer I am not aware of all the administration problems but I do know that several staff people put in many extra hours at work, especially the program manager and the director of volunteers. Dedicated volunteers see a need and work hard to fill gaps.

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. I understand that all of the CSFP's for the elderly have long waiting lists. How long is your waiting list currently?

Answer. There are approximately 500 applicants on the Des Moines waiting list.

Question. I understand that you no longer conduct program outreach. Could you please explain why you have discontinued this?

Answer. Because it is almost tragic to advise needy people that their name will be put on a waiting list that long I did not continue going into homes to help make out the lengthy certification papers.

[The prepared statement of Ms. Carpenter appears at the conclusion of the hearing, see p. 71.]

Mr. PANETTA. Thank you, Ms. Carpenter.

The Chair now recognizes Dr. Lipschitz.

STATEMENT OF DAVID LIPSCHITZ, M.D., DIRECTOR, GERIATRIC RESEARCH EDUCATION AND CLINICAL CENTER, JOHN L. McCLELLAN MEMORIAL VETERANS HOSPITAL, LITTLE ROCK, AR

Dr. LIPSCHITZ. Thank you very much, Mr. Chairman. Thank you for allowing me the opportunity to testify.

Do we as physicians see the complication of hunger in our hospitals? The sad answer is yes.

In the Third World protein calorie malnutrition is a disease of children. In this country it occurs most frequently, if not exclusively, in the elderly. Even in the elderly, malnutrition usually occurs in individuals who have coexisting diseases such as cancer or infection, which suppresses the appetite and alters metabolism so that malnutrition develops.

Not uncommonly, however, elderly subjects come to the hospital with ever-increasing frequency with primary protein calorie malnutrition that directly results from an inadequate intake of food.

A classic example of such a case is Mr.—whom I will call Mr. Joe Smith, a distinguished World War I veteran from a small town in Arkansas, 84 years of age, lives by himself, who has no relatives living close by. He ate meat once weekly, and persisted mainly on cereal. One day he was found, confused, in his room by a neighbor. He was admitted to our Veterans' Administration hospital. He was confused, dehydrated, and he had an infection, and was grossly underweight.

Fortunately, we recognized that this neglected man was profoundly malnourished. He was treated appropriately, and after a 42-day stay in the hospital, was entered into an independent living program with other individuals of the same age, and he still 3 years later is leading a productive life.

Patients don't come to hospitals saying "Doctor, I'm starving, please help me." Rather, they present with complications of malnutrition; namely, infection, dehydration, and confusion.

Most health care professionals are poorly trained in nutrition, and it is an unfortunate fact that the diagnosis of malnutrition is frequently overlooked, and often missed. This often results in disastrous consequences.

Frequently these subjects require 6 or more weeks of hospitalization. They often require feeding through a special tube that is placed through their nose and into their stomach; and essential to

61-275 O - 86 - 2

their management is a comprehensive economic, social, and medical evaluation that insures that the problem does not recur.

I would like to specifically focus on the special challenges for the future. I cannot overemphasize the importance of research in understanding the complex interaction between nutrition and aging, and approaches to preventing serious nutritional deficiencies from developing.

This research should include basic biomedical approaches, but also psychosocial and community studies that address the very core of the problem.

There is a great need for more emphasis on nutrition education for physicians and all other health care professionals, and also a need for the health care community to develop an understanding of the special problems of older Americans.

The special additional challenge is the change in the way in which we are practicing medicine. Providing 6 to 8 weeks of rehabilitation in an acute care facility is no longer an option under the disease-related group reimbursement guidelines.

The Veterans' Administration has provided, I believe, a leadership role for the Nation in intermediate and long-term care rehabilitation for the geriatric patient. These programs have clearly been shown to be cost-effective by minimizing the need for institutionalization or nursing home placement, and preventing recurrent admissions to hospital.

This model of geriatric rehabilitation has unfortunately not been extensively developed in the general medical community. There is clearly, in my opinion, a need to develop intermediate care hospital beds where elderly subjects with nutritional and other problems can be cared for in a cost-effective manner. This concept of short-term, long-term care is one that cannot be overemphasized.

An additional major need is to assure that compromised older individuals who are likely to have nutritional and other problems, have easy access to community support services.

As you have heard already, and I'm sure you'll hear more of, there are certain issues with regard to community support that require urgent attention.

It is apparent to me, and all the other witnesses, that there are a large number of neglected elder citizens in communities across America who either are unaware, or who for various reasons are unable to become eligible for urgently required nutritional and other support services.

Finally, I must add that I believe that the solution to the medical predicament of hunger in elderly individuals involves a restructuring of our medical and social priorities. By paying attention to the health and welfare of older individuals, and by assuring their continued productivity, we will minimize the opportunities for creating nutritional deficiencies, and hopefully by a process of disease prevention and health promotion, minimize the need for expensive medical resources.

A preventative approach to disease will also hopefully substantially improve the quality of life of older Americans, and allow them to remain independent on the community for as long as possible. Thank you.

[The prepared statement of Dr. Lipschitz appears at the conclusion of the hearing, see p. 73.]

Mr. ROYBAL. Thank you, Doctor.

Ms. Carpenter, I'd like to start off by examining a little further some of the points that have arisen from your testimony.

But before I do that, I would like to compliment you on your hard work in helping to get essential nutrition assistance to those that are most in need.

Are you aware of any homebound and isolated senior citizens in your area that you cannot serve at this time due to insufficient funding?

Ms. CARPENTER. That's right. The number that could be served was frozen at 4,200, and I believe if you would go through Velma Flisher's testimony, Velma is the director of the program. It has all of these facts in it. It was frozen at 4,200 when we had assumed it was going to be 5,000.

Mr. ROYBAL. So the need then is——

Ms. CARPENTER. The need is there.

Mr. ROYBAL. The need is to serve 5,000 but you can only serve 4,200?

Ms. CARPENTER. 4,200. I understand is just within the last several weeks that they have been informed that the project is going to become a program like the butter and cheese, which would allow it to go all over the United States, like the butter and cheese.

But it has to be, and this is one of the restrictions, if they—if some organization, or some county decides they would like to take it on in another State, it has to be a place that already is serving CSFP. They have to have one in operation. If they can, then they will be allowed to start the commodities for the homebound elderly over 60.

Mr. ROYBAL. Well, first of all——

Ms. CARPENTER. If that happened, then Des Moines could go way over 5,000.

Mr. ROYBAL. So, in other words it could be higher but based on the figure of 5,000 there are at least 800 elderly in your area who cannot be served due to insufficient funding and resources? Is that correct?

Ms. CARPENTER. That's correct. According to the 1980 census figures, Polk County has approximately 11,000 low-income elderly. Actually, the figure that they were authorized to serve was 4,102 instead of the 4,200.

Mr. ROYBAL. Ms. Carpenter, what I was interested in was not necessarily statistics, but your experience. Based on your experience, how many senior citizens do you believe were not being served due to insufficient funding and resources? Is the correct figure in that case still about 800?

Ms. CARPENTER. That's right. Now——

Mr. ROYBAL. Now, in the other panel we were told that individuals were not participating in the Food Stamp Program.

Is it your experience that older individuals have low participation rates in the Food Stamp Program?

Ms. CARPENTER. It is very small. Part of that is because the Food Stamp Program, the people that I have been to who have been on it have been getting about $10 in food stamps, and it means they

have to go out to a place, make out the applications, and transportation for these homebound people is tough. And they do not like—the older people do not like to go out begging for someone to do this and to do that for them. And so a lot of them will say if I only get $10 it isn't worth it.

Mr. ROYBAL. Thank you, Ms. Carpenter.

[The prepared statement of Ms. Flisher appears at the conclusion of the hearing, see p. 78.]

Mr. ROYBAL. I'd like to ask the Doctor a question regarding his statement that the highest prevalence of protein calorie malnutrition is in hospitalized elderly patients.

You go on to say that most evidence suggests that at least 65 percent of elderly individuals admitted to hospitals have a serious nutritional problem.

So they're admitted to the hospital with a problem of malnutrition. How do they leave the hospitals? With the same problem?

Dr. LIPSCHITZ. Well, I would say that that is variable. If you're a veteran in a Veterans' Administration hospital that has a lot of resources, the chances are the comprehensive programs to optimize nutritional and other help is available, so that they may leave appropriately.

In most communities, however, those options are not available.

I might mention that in the vast majority of older individuals who present to hospital with malnutrition, they do have a coexisting serious medical problem that is often not completely correctable.

But even then if a medical problem is not terminal, paying attention to their nutritional needs can clearly improve the quality of their remaining life.

Mr. ROYBAL. But their medical problem is compounded by the fact that they are suffering a malnutrition?

Dr. LIPSCHITZ. That's true.

Mr. ROYBAL. Doctor, do the hospitals make any attempt to try to correct the problem so that when the person leaves the hospital he or she is better taken care of nutritionally than before he was admitted?

Dr. LIPSCHITZ. I would say my answer is it varies from hospital to hospital. That in some places that are attuned to these particular problems, the patient is likely to have those particular issues addressed. In the vast majority of communities, however, that is not the case.

Mr. ROYBAL. So that in the vast majority of communities, if the patient comes into the hospital with a nutrition problem he or she leaves the hospital with the same malady?

Dr. LIPSCHITZ. That's correct.

Mr. ROYBAL. Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. Before I ask questions, I'd like a unanimous-consent request that members be allowed to put their opening statements in the record.

Mr. ROYBAL. Without objection, it will be ordered.

Mr. LIGHTFOOT. Thank you.

Ms. Carpenter, you have worked as a volunteer delivering food to a lot of people who need it. In earlier testimony we were talking

about some of the factors that keep people from asking who have a genuine need.

No. 1, do you feel that's a fair perception? Are there a lot of people that really do have a genuine need but for whatever reason they don't participate, don't ask?

Ms. CARPENTER. I definitely feel that way.

Mr. LIGHTFOOT. How can we get to them then, I guess is the question?

Ms. CARPENTER. I stayed long enough to get that dispelled, that feeling. Hopefully when I have gone out I have been able to stay and visit with those people long enough that they determine I believe I want them; I will make out the application. But it is true. Many of them have never had to ask for help.

Sometimes they don't want the people in their neighborhood to know that they're getting help. So there are factors that do keep many of them from asking.

Mr. LIGHTFOOT. You've been working basically in Des Moines, which is an urban area. As we get out into the smaller communities, and out into the rural areas, we have more problems with distance, and these types of things. There also seems to be more of a reluctance to participate in these types of programs.

Ms. CARPENTER. That's true too.

Mr. LIGHTFOOT. How do we reach them? How do we get the message that it's there, and if they have a need they should ask?

Ms. CARPENTER. I think that if in the small communities if you can find the right people—now, that isn't going to be easy because it has to be someone that can go, I feel, and visit with these people personally.

Like in the town that I live in of 1,400, if I—and I know the hungry people—instead of calling them up and saying "Why don't you go and do this?" I would go and sit down with them and visit with them. I'm very much a person that believes a look in the face is better than handing them a piece of paper and saying fill it out.

But that's a major, major task to get that done.

Mr. LIGHTFOOT. In your opinion, is it just the poor elderly people that are in this situation, or do we find people who possibly are not that short on means but due to whatever reason their nutritional level is not where it should be?

Ms. CARPENTER. I find many people who are living at a level that I might say is satisfactory, and is serving them in a mediocre way, and they are getting commodities. And hopefully it's making a better life for them. They aren't all way down at the $289 Social Security level, or the $312. Is that what you meant?

Mr. LIGHTFOOT. You also mentioned—if I could backtrack just a bit, the idea of finding an individual, someone in a community, an entity to be a contact point or volunteer, whatever, to work with people. It's obvious that you have been very active in doing that. Do you think we have people like that in communities that are willing to volunteer? Are there enough volunteers out there to do this type of thing if we get the message out to them?

Ms. CARPENTER. I think if it's handled properly you can get it out and get it to them. I think—I feel I could go to Coon Rapids and get some people to help me to go out and do this, but I think a first-hand contact is really important.

Mr. LIGHTFOOT. Thank you.

Doctor, one quick question. One thing that we're really concerned within, rural America is something you alluded to a moment ago, particularly the DRG system, which basically is resulting in sicker people being admitted to hospitals, and also being turned out in poorer condition at the end of that stay.

How much of this is pretty abstract. You may not be able to answer this. But how much of the sickness problem, if we want to put it that way, amongst the elderly can be traced pretty much directly to nutrition? In other words, if they had a good meal, and they were eating properly, these symptoms and diseases and so on wouldn't necessarily develop, or they'd develop at a lesser rate?

Dr. LIPSCHITZ. I think there's a desperate need for more study on the long-term effects of nutritional changes on how an older person presents with diseases. But there's no question that either overnutrition or undernutrition can compromise the older person in terms of his or her diseases.

I might also make a point with regard to the DRG's. There's no question that sicker people are being sent home earlier, and that multiple readmissions to hospital is a serious concern. As a result, hospitals are going to become more appropriately focused on the issue of discharge planning.

I think the DRG system has great merit. I think there are holes in it which could be plugged by developing long-term care options that allow people who are too well to stay in an acute care hospital but too sick to go home to have a transition environment where they can be rehabilitated.

And that's the challenge for the future in terms of the medical issues and DRG's.

Mr. LIGHTFOOT. I guess to follow up on that, the purpose of the DRG's was to get health costs down, but now it appears that we've got a problem with quality. We did get the cost down, but the quality has suffered considerably, particularly, again, I guess the areas we're most familiar with, rural areas. We have many of our hospitals where there's a very real possibility they will close because censuses have gone down and so on.

At Mrs. Bentley's hearing yesterday, it was suggested as a possibility that the hospital could provide for certain treatments a function almost like a hotel, whereas, strictly for an elderly person they had an early morning operation procedure. Rather than putting them in the hospital with all those attendant costs, they could stay there something like an overnight type charge, and so on.

Do you view that as maybe a possible answer, or a portion of the answer?

Dr. LIPSCHITZ. I think the answer to rural America's health care needs is to restructure the priorities; the priorities for those rural areas are not to provide sophisticated care, but to provide long-term continuity of care.

I would suggest that at the current time those hospitals are not attuned to long-term care. We have not trained any physicians in this country in the whole concept of providing long-term care to older people who require a long period of hospitalization.

That's why the geriatric medicine initiative is so important. We need doctors throughout this country, particularly in private care

areas, who understand continuity. We need hospitals in rural areas that are not concerned with doing major sophisticated surgical procedures, but in providing a place where a person can be close to their home while they could perhaps recover from that intensive procedure that might be required, or might be more appropriately done at a tertiary care facility.

So I think in the next 4 or 5 years you'll see a complete restructuring of the way in which health care resources are funneled, and I hope that will be a good thing for the system.

Mr. LIGHTFOOT. I thank both of you for your excellent testimony. Thank you, Mr. Chairman.

Mrs. BENTLEY. Thank you, Mr. Chairman. I want to thank both members for making this very important point here today, as I've been a long-time advocate of the nutrition of all individuals, particularly the elderly.

Ms. Carpenter, we do have in Maryland the giveaway program for the surplus of food. I don't know that we have anybody who goes around to those that are confined to their homes like you do, and I'm going to check on it to see. That's a very commendable program for the aged. It's very helpful and important.

Dr. Lipschitz, is there anything being done by the AMA to train or to get doctors interested in this long-term care you're talking about?

Dr. LIPSCHITZ. Once again, the major initiative in long-term care, and I think that really equates with geriatric medicine, has really been pioneered by the Veterans' Administration.

We currently, the Veterans' Administration, trains about 30 to 40 geriatric physicians annually. Each of those physicians is like a first round draft choice in a major league sport. He can—he or she can go anywhere they like in terms of providing a position for him. So there really is a tremendous need, and there is an awareness that there is a need. But programs are slowly developing in the community to address them. But, in my opinion, there could be more.

Mrs. BENTLEY. Programs in the community, more in the local areas rather than in——

Dr. LIPSCHITZ. Well, I think any major training program should focus on training their young doctors and other health care professionals because the key aspect of providing care to older citizens is that it is a team approach, that it is a combined physician-nurse-social worker and other health care professional using their combined expertise to appropriately and comprehensively assist an older individual. So there is a need for training in all areas.

One of the major programs that has been set up in about 15 States is the so-called geriatric education centers which were funded by the Health Services Resource Administration. Unfortunately, the goal of that program was to have a geriatric educational center in every State. Of course, that is not going to happen.

That kind of program will be very beneficial in providing a health care network that understands the special needs of older Americans.

Mrs. BENTLEY. Do you know of any of the old medicines have——

Dr. LIPSCHITZ. Well, in your home State of Maryland one of the most outstanding aging programs is at Johns Hopkins School of

Medicine, and there are numbers of good programs nationwide, including Arkansas.

Mrs. BENTLEY. Thank you, Mr. Chairman.

Mr. HERTEL. I want to thank the panel very much, and I think the staff will have some additional questions for you at another time.

Thank you very much.

I begin by calling the next panel, the third panel up.

First I'd like to introduce Bill Moyer. He's the director of the King County Nutrition Program in Seattle, WA. He's the past president of the National Association of Nutrition and Aging Service Providers. From a local and national perspective, Mr. Moyer will discuss ways to more effectively use our Federal dollars and commodities to serve the elderly in need of prepared meals.

I'd like to ask Congresswoman Bentley, please, to introduce Senator Abrams from Maryland.

Mrs. BENTLEY. I'm very pleased to do that. As I said a few moments ago, Mr. Chairman, State Senator Rosalie Abrams has been an outstanding person in Maryland in political life for the past years. She is now the director of the Maryland State Office on Aging.

As a former Maryland senator, and chairperson of the State Finance Committee, she was responsible for the passage of legislation establishing community based services for elderly in Maryland. And when she was appointed as director of the Office of Aging, her constituents were very upset about it, but they likewise recognize the fact that this was a very important position, and knew that she would do an outstanding job as she has.

Accompanying her is Janet Martin, who directs the elderly in nutrition services for Maryland, and served on the Governor's recent Task Force on Food and Nutrition.

Senator Abrams will provide the committee with information on cost-effectiveness, food programs for the elderly, and will focus her remarks on the particular food needs for the growing population of homebound elderly.

Welcome, both of you, from Maryland.

Mr. HERTEL. The third person we have on the panel today is Mr. Suzuki. He is the Associate Commissioner for the Office of State and Travel Programs at the Administration on Aging. He will provide the committee with information on the administration of the title III-C nutrition programs.

We had invited a representative from the Office of Management and Budget who oversees the program management of all food assistance programs for the elderly. They declined our invitation.

So I am hoping Mr. Suzuki can offer the committee information on both the HHS funding and USDA cash and commodities for title III elderly nutrition programs.

We've got a vote underway, but let's take a few minutes. Mr. Moyer, if you could submit your statement for the record, and begin your testimony at this time.

STATEMENT OF BILL MOYER, DIRECTOR, KING COUNTY NUTRITION PROJECT, SEATTLE, WA

Mr. MOYER. Thank you, Mr. Chairman. I have submitted my testimony for the record, and in the interest of brevity, I will only highlight here.

Hunger in America is increasing. All who have examined the problem in the last 4 years have come up with the same inescapable conclusion. Hunger is on the rise, and that fact is a direct result of public social policy that has seen programs cut, appropriations shifted elsewhere, and policies seemingly designed to fail in combating hunger.

Those of us who work in programs to serve the elderly, the congregate and home delivered meals programs, can't keep up with the need.

Requests to open new congregate sites cannot be honored. And the impact of DRG's on the home delivered program has pushed service requests beyond 30 percent nationally.

To help meet this increased need nutrition programs for the elderly have increased the number of meals served, despite no increase in Federal dollars in terms of real or constant dollars.

Between 1981 and 1985 meals increased from 188 million nationally, to 225 million nationally. How? The low-income elderly paid for them.

Participant donations have increased in the same 4-year period of time from $71 to $121 million. There is a limit to how much longer we can expect low income elderly to shoulder the financial burden of this program without cutting services.

Hungry older people obviously need your help. There is much that oversight and legislative committees can do to help alleviate this problem.

You can continue your strong historical support of the USDA Cash/Commodity Program.

You can continue the National Commodity Processing Contracts Program. This, as you may know, is a program that allows manufacturers of various food products to utilize the surplus commodities, and then to pass the savings onto projects either in the form of a discounted price, or a rebate. That program was slated for closure under the current administration last July. It has been extended, I believe, 1 year, possibly 2, but it needs your protection.

It would be wise for the committee to do what it can to remove the requirement that only those States that have elected to receive at least 51 percent commodities versus cash, are eligible to receive nondairy bonus commodities, such as ground beef, poultry, fruit, and vegetables that are available.

This is particularly important in view of the fact that there is going to be an anticipated large surplus of beef made available this year, and it would be good if we could utilize that product in serving older people.

Related to the first few points, insure that as much flexibility as possible exists for nutrition projects to benefit from surplus commodity foods. To have surplus commodity foods rotting in a warehouse when we have older people going hungry is senseless.

You can also simplify the application process for food stamps. We've heard from other witnesses that few of the elderly participate in the Food Stamp Program. Another of the reasons that has not been cited is the very application process itself.

Although much can be done legislatively, if the problem of hunger is to be seriously addressed, additional funds are necessary.

Congregate and home delivered nutrition programs are good programs. They are well managed; they effect the nutritional well-being of those who participate, and they're very well accepted by the elderly themselves.

We do not need better programs. We need better funding for the programs we have. Over half of the support for the congregate and home delivered nutrition programs currently come from either the participants, or from community support in the form of facilities, the donation of utilities, equipment, and places to hold the congregate programs.

It's an excellent example of a public-private partnership, and it needs to be reinforced.

Mr. HERTEL. Mr. Moyer, we're enjoying your testimony, unfortunately, everyone left because we—there is a vote on. I'm going to have to go over and vote. I hope to be back. But in any event, the hearing will continue, and I want to apologize to this panel for the fact that it is late in the day and we are voting on the House floor. I apologize to you. We'll take your testimony up, Mr. Moyer, when we resume.

[Recess.]

Mr. PANETTA. The joint committee is back in session. We will continue these hearings. I apologize. The longer hearings drag out the more we begin to lose memories because of other commitments, and that includes myself.

Mr. Moyer, I think you were testifying at the time we concluded. Did you complete your statement?

Mr. MOYER. Mr. Chairman, in the interest of time, I have concluded. I will consider my testimony concluded and defer to the next witness.

Mr. PANETTA. OK. Thank you.

RESPONSES TO QUESTIONS FOR BILL MOYER

QUESTIONS SUBMITTED BY HON. LEON PANETTA

Question. Congress passed fiscal year 1986 appropriations legislation making available funds for a 56.76 cent reimbursement rate for each of the 225 million meals served in fiscal year 1985. I know that the USDA, however, has not adjusted the reimbursement rate yet. We have now passed an authorization bill, signed into law earlier this month, raising the authorization ceiling to allow for the 56.76 per meal reimbursement. Still, USDA has not increased the reimbursement rate for fiscal year 1986. How does this impact on elderly nutrition services currently and program planning for the future?

Answer. The failure of USDA to increase the per meal reimbursement rate intended by Congress in a timely manner frustrates nutrition program directors, needlessly reduces nutrition services for the elderly, and may risk an understatement of the need for meals and other nutrition services in this country. Currently, most States are quoting very conservative per meal reimbursement rates to nutrition projects, in some cases as low as 40 to 45 cents per meal. At the same time we are appropriately required to develop balanced annual budgets. The result is that with less money, we currently provide less service. While meals have increased national-

ly, some projects have had to reduce meals. All projects have reduced some nutrition related services to include Outreach, transportation, and nutrition education.

Program planning for the future will most assuredly result in reduced meals. Most programs have, by now, made every program efficiency possible, increased participant donations to the maximum, if not dangerous, level without dramatically effecting the participation of target low-income participants, and have made the nutrition service reductions mentioned above. For meals to be reduced as a result of bureaucratic lethargy is cruel and disgraceful and must not be tolerated.

The final straw of such administrative delays is to finally approve a rate so late in the year that it cannot be prudently expended resulting in either waste or a carry-over that might be interpreted by some as proof that the appropriation was too high. Meanwhile hunger continues to rise among the elderly.

Question. How do the past and pending changes in USDA reimbursement rates per meal compare to changes in actual meal costs?

Answer. In the past, the per meal reimbursement rate was as good as the USDA estimate of the anticipated number of meals to be served in a given year. In the distant past the estimate was good. In the not too distant past a supplemental appropriation was required to allow the established per meal rate. In the recent past, the rate per meal was reduced resulting in a $7 million loss. At present USDA is doing nothing. This approach serves to penalize programs for being successful. I'm not sure I understand.

If I have misunderstood your question and if your question is how does the increase in the per meal rate compare to the increases in the total meal cost, then I would say it is fine. Meal cost, like the USDA reimbursement rate has been fairly stable in recent years.

Question. What recommendations do you have that will both assure a predictable reimbursement rate per meal at the beginning of each fiscal year and retain the current categorical funding status of the program?

Answer. A predictable reimbursement rate per meal at the beginning of each fiscal year and the retention of current categorical funding status for the program are two separate issues and should be dealt with separately as they have been for the past 12 years, despite recent efforts to apparently tie the two together. This is due to the fact that two separate departmental appropriations are involved. To insure a predictable reimbursement rate per meal at the beginning of each fiscal year, set the per meal rate, tie the expenditure to meals served, and appropriate an amount of funds 20 percent above USDA's best estimate. To retain the current catagorical funding status of this program, which we wholeheartedly support, simply continue the Older Americans Act as it was envisioned and as it has been funded since 1972. This Nation needs model social programs that do what they were designed to do. Now that we have one, let's keep it.

Follow-up: How could we incorporate these into legislation?

Answer. Other than the recommendations already made, I would recommend that Congress require USDA to distribute the per meal reimbursement rate established by Congress to the States within 30 days of the President's signature on the appropriations bill, that the USDA estimate the number of meals for which the reimbursement rate is to be applied from the four quarter period ending June 30 of the previous fiscal year, and that USDA show just cause for noncompliance if unable to meet this requirement.

Question. We know that in the past elderly nutrition program administrators preferred cash over commodity reimbursements for meals. Your testimony and information Congressman Leland provided from the Texas State Office on Aging indicate a reversal of this preference. Is this a national trend among elderly nutrition service providers and could you please explain the change?

Answer. Perhaps I presented confusing testimony. There has been no change in the preference for cash over commodities by nutrition program administrators. While I cannot address Congressman Leland's position, the national trend is unchanged. My testimony addressed the support for the national commodity processing contracts and extending the availability of nondairy bonus commodities to projects receiving cash. Both could then be participated in by projects without effecting their cash allocation. Currently N.C.P. products and bonus dairy commodities are utilized by projects receiving total cash reimbursement. However, far greater benefit could be realized from commodities by changing regulations and that was the essential point of my testimony.

Follow-up: What are the barriers to using commodities versus cash in the elderly nutrition programs and how might they be alleviated at the administrative and/or legislative level?

Answer. While I am optimistic for the future, there continues to be a number of barriers to using commodities. Historically there has been a problem of the appropriateness or suitability of the commodity items for the elderly, that is, high sodium processed beef and cheese, corn syrup, pinto beans, et cetera that made full utilization and therefore benefit impossible. Other problems in utilizing commodities in lieu of cash include minimum orders from N.C.P. processors; storage, transportation and other hidden costs to receiving commodities such as minimum in/out charges per shipment and per case; the unpredictability of items to be available and the unpredictable arrival times; bureaucratic foul-ups at the State level; last minute take it or leave it offers; and the problem of attitude due to historical problems in understanding USDA policies and utilizing the commodities. Most of these problems, however, I think could be solved administratively.

Finally, I feel I must say that where commodities are used in lieu of cash, the commodities are essential to the efficient operation of the program. I urge Congress, again, to pass legislation that allows much flexibility at the project level to elect cash or commodities and that greater access to existing commodities be made possible for program directors.

Question. Mr. Hutton earlier recommended that title III nutrition providers inform eligible participants about the Food Stamp and Supplemental Security Income Programs and assist them in participating. What resources would be necessary to assure that such information and referral occurs.

Answer. Most title III nutrition providers are informing participants at present about Food Stamp and Supplemental Security Income Programs and most, if not all, nutrition providers accept food stamps as a donation to the meal program. The informational process may be to inform the participant as to where to go to have eligibility determined, inviting representatives into congregate nutrition sites to inform participants of the programs and direct assistance on behalf of the participant. Unfortunately, aggressive outreach, advocacy, referral, and follow-up services have been progressively reduced or eliminated as title III–C funds have been transferred to title III–B services to include case management and transportation, and most nutrition related service staff have been terminated to avoid cutting meals. Again, however, to do the best job will require more staff time and more staff time will require more financial support. While informational materials are helpful, adequate referral, assistance, and follow-up require staff.

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. From your working relationships with USDA what evidence do you have to support your statement that this administration wants to discontinue or weaken the commodity processing option for elderly nutrition services?

Answer. The N.C.P. program became law on March 24, 1983. The first that many of us heard about the program was about 1 year later through aggressive questioning and through private industry, not the efforts of USDA. The first communication of any detail from USDA to my project was March 8, 1985, 2 months before the issuance of the USDA memo dated May 28, 1985 announcing the expiration of the N.C.P. program effective June 30, 1985.

Despite protests from the field, this action put some N.C.P. processors out of business who could not wait out the time for the program to begin again. It was only after a congressional directive that USDA sent another memo to the field, dated November 25, 1985, announcing the continuation of the program through June 30, 1986. This was despite the fact that the extention of the N.C.P. program was signed by President Reagan on August 15, 1985. Such administrative delays continue. For example, despite the fact that the N.C.P. program was again extended through June 30, 1987, back in December 1985, nutrition projects have not been notified nor have they been given a listing of approved N.V.P. processors, a questions and answers manual or any information that would allow us to take advantage of this program.

These actions or nonactions by USDA, coupled with the administration attempts in 1981 and 1984 to eliminate the USDA commodity/cash option in the reauthorization of the Older Americans Act indicated less than enthusiastic support on the part of this administration for the commodity processing option for Elderly Nutrition Programs.

Question. Are you able to provide outreach to serve those low-income elderly who are most in need of nutrition services to prevent hunger?

Answer. In a word—no! Outreach as a mandated service was eliminated in 1978. Outreach as a service was, in many parts of the country, defined by area agencies on aging as access not direct services and began being administered by AAA's, not nutrition services providers. Then, the outreach services became case management

services, again administered by area agencies, and now most money goes into case management not outreach. At this point, we hardly have sufficient staff to put the meal on the table, let alone perform aggressive outreach services.

Follow-up: What can we do from the Federal level to assure this type of outreach is implemented nationwide?

Answer. Prioritize it, require nutrition providers to perform it and fund it adequately.

[The prepared statement of Mr. Moyer appears at the conclusion of the hearing, see p. 83.]

Mr. PANETTA. Ms. Abrams.

STATEMENT OF ROSALIE ABRAMS, STATE SENATOR, DIRECTOR, MARYLAND STATE OFFICE ON AGING

Ms. ABRAMS. Mr. Chairman, I too have submitted a statement revised as of this date, and I would appreciate it if you'd enter that in the record.

I did want to make several points to the committee, and one of the issues that—having served in the legislature for 18 years on the budget committee, I would like to respond to the question you raised earlier: Is nutrition a cost-effective program? The answer is definitely, yes.

I would like to make a few points about that issue. I know you've heard from Mr. Driggs and Dr. Lipschitz, but I'd like to expand on some of the testimony that's been given.

We have studied nutrition over a period of time, and more recently we've discovered that nutrition, adequate nutrition, is connected with maintaining good health. Undernutrition is definitely concerned with weakening the immunological defenses to the point where it's been demonstrated that people may be more susceptible to many illnesses such as cancer.

Undernutrition is involved with such serious killers as osteoporosis, particularly in older women, the cardiovascular diseases, high blood pressure, diabetes. Those are the four major illnesses that we've noted have definite implications of diet.

I've put this chart up because I think you have to look at the demography, and I know you've seen it before, but Maryland is typical of what's happening in the rest of the country. The percentage of increases going up most rapidly is among the old, old.

The old, old are the most susceptible to illness. The older you get the more apt you are to pick up a chronic disease, and the truth is that old people are hospitalized almost twice as often as the young population. They stay sick twice as long. They use twice as many prescription drugs. They account for one-third of the country's whole health care expenditure.

Medicare pays for 50 percent of the personal health care in this country—Medicare, for people over 65.

The hospital costs account for 69 percent of Medicare dollars, so the dollars in Medicare are spent for people in acute situations.

You've heard some testimony from Dr. Lipschitz about what's going on in the Veterans' Administration. Let me tell you though, and I see in his own testimony, often the admitting physician doesn't recognize that undernutrition is the underlying cause of a illness.

The truth of the matter is that even in Maryland, which is one of the better States as far as programs for the elderly is concerned, geriatric education is not required for medical students. We are just now beginning to develop programs that will be mandated for medical students, future doctors, who are not required to take courses in geriatrics at the present time. And I think this is typical of what's going on around the country.

As far as poverty is concerned, people over the age of 75 are twice as apt to be poverty stricken as those between the age of 65 to 74. The new cohorts coming along in the elderly unfortunately were young during periods of better economic times and are now eligible for private pensions and Social Security; whereas in the over 75 and older group, two-thirds of them are women, most of them grew up during the Depression, did not have an opportunity to earn money, nor to earn credit for Social Security.

As far as hospital costs are concerned, in a study that was financed by the Abbott Laboratories just recently, the poorly nourished patients had three times the number of major complications. They were three times more likely to die. They cost almost twice as much for hospital care as people with good nutrition. They stayed longer. They cost more per patient. And undernutrition makes a serious contribution to prolonged illness, and prolonged treatment in hospitals.

Another study that was done at the University of Illinois found that among people who were adequately cared for, people who participated in meal programs, almost a majority of them did have adequate vitamin levels, and adequate nutrition levels. Even participating in the Congregate Meal Program does that.

It isn't just the poor, incidentally, who are undernourished. It's the wealthy too. And one of the main reasons to have the Congregate Meal Program is to bring people out of isolation, as well as to encourage them to eat properly, and to get adequate nutrition. And undernutrition is not just in the poor. It's worse in the poor because they don't have access to food. And I hear your bell ringing again.

But at any rate, I did want to say that it is cost effective. We have a program in Maryland under which I chair an interagency committee comprised of myself and secretaries of the department of health and mental hygiene and the department of human resources. We coordinate community care for disabled people living at home. And if you don't have one piece of the system, you can't keep people at home. If you don't have an adequate nutrition program, you're going to institutionalize people.

We demonstrate that the cost of maintaining people at home is about one-third of what the whole public cost is if they are institutionalized. The program costs about $246 per individual per month, and if they're under Medicaid, which is part of their eligibility criteria, all public costs together would be about $846. It is a cost-effective program.

I think it's important to keep that in mind. One other point I did want to make. We are suffering in Maryland because we did a good job as far as the commodity food reimbursement is concerned. We stayed within the budget. The States that didn't stay within the budget are now reaping the benefit of serving the extra meals. And

we're being penalized for 1985, 1986, and looking forward to 1987. We don't even know what to budget yet for 1987.

So that's one of the big problems we have. I think it's terrible that Gramm-Rudman didn't protect the food programs for the elderly. Incidentally, we call the program Eating Together in Maryland. I like it better than Feeding the Elderly. In case you're thinking of making a change, I would recommend that you do that.

There is a stigma involved with taking food stamps, as with taking any kind of charity.

In one of our counties—I just wanted to mention this program—we spend about $5 a trip per week per client to bring food to them. We also get drugs for them as well. This is one of the ways in which we can overcome the stigma, take people to a different part of the community to do their shopping with food stamps, and in some places you might want to have delivery of food to them. There are all kinds of ways to deal with this.

To summarize, it's a cost-effective program. Good nutrition means a great deal to the elderly. The importance of the preventative care cannot be over estimated. We can begin educating people but you have to start when they're fairly young.

So I again thank you for inviting me to come and share some of our experience with you. I'll be happy to answer any questions.

RESPONSES TO QUESTIONS FOR ROSALIE ABRAMS

QUESTIONS SUBMITTED BY HON. LEON E. PANETTA

Question. You mentioned many cost-saving techniques implemented over the last 4 years by title III–C program administrators and supplemental funding from localities and the State. To what extent can the costs per participant be further reduced and local funds be further increased to provide for expansion without Federal funding increases at this time?

Answer. Cost-saving techniques implemented over the last 4 years by the title III–C program administrators in various localities of Maryland have included the following:

a. Consortium contracting, we have encouraged our nutrition program administrators to advertise for competitive bids for supplying food service to our projects. As a result of this, we have four projects using the same caterer which allows for savings in meal cost. The four projects use the same menu and the same style of service, resulting in below-average meal costs; and a savings of $116,000 per year.

b. We have increased the number of volunteers in our program as follows: 1982, 4,586; 1983, 5,549; 1984, 6,952; and 1985, 7,813.

Volunteers work as site managers, kitchen crew, janitorial support and program helpers.

c. We changed some of the menu configurations to use less expensive foods, that is, we changed whole milk to 2 percent low-fat milk. In view of all of the recent research, the change was healthy and less expensive. At 3 cents per one-half pint, approximately $76,000 statewide is saved per year.

d. In creating new sites, we have asked that 100 participants have indicated an interest before establishing a nutrition site. We feel that we should have at least 20 to 25 participants present every day to make the cost of operating the site economical. We have always located sites to which many of the participants can walk, thus reducing transportation costs. According to the Eating Together in Maryland study, 25-percent of participants walk; 40-percent drive or use public transportation. Only 23-percent use special transportation provided by the Area Agencies on Aging.

e. Expand project income, we have increased the average participant voluntary contributions by 36-percent.

	1984	1985
Meals	3,681,535	3,088,399
Income	$1,570,484	[1] $1,271,835
Average participant contribution	42.6¢	58¢

[1] Gross income is less because of fewer meals served, but average participant contribution is higher. We have always used project income to serve additional meals.

f. To provide expansion without Federal funding increases at this time is indeed difficult. Many of our sites operate in rent-free space; heating and lighting is furnished by the community and the county governments. The total local support was $870,000 in 1985.

For fiscal year 1987, the Governor and legislature have appropriated $400,000 for the nutrition program. This money will be used to supply at least 40-percent home delivered meals and 60-percent congregate meals. This will result in 176,452 more meals being served.

Question. What was the impact of the recent sequestration of funds as a result of Gramm-Rudman-Hollings Act on your meal programs and related supportive services?

Answer. The recent impact of the sequestration of funds as a result of the Gramm-Rudman-Hollings Act on our meal programs and related support services is that we have been denied about $125,000 in commodity reimbursement funds. With this money we could have served an additional 100,000 meals.

Question. How has the Federal initiative encouraging increased participant contributions for title III meals impacted on the participation of poor elderly in the programs?

Answer. The Federal initiative encouraging increased participant contributions for title III meals has discouraged some of our poor elderly to participate in the programs as often. Our project directors report that some individuals are coming to the site less often. They are reluctant to press for increased contributions, lest such undue emphasis result in subverting the basic purpose of the program.

Question. If the availability of commodites were increased in the USDA administered reimbursement for elderly meals, would this allow you to expand services?

Answer. If the availability of commodities were increased in the USDA administered reimbursement for elderly meals, we would be expanding services according to the amount of that particular increase.

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. How have the low-income elderly in financially depressed geographic areas been adversely affected by the cuts this year and in recent years in title III elderly nutrition and supportive services?

Answer. The low-income elderly in financially depressed geographical areas have been adversely affected by Federal funding for the title III elderly nutrition and supportive services projects. A decrease of 4-percent in the total number of meals served in the State is expected in fiscal year 1986 based on an increase of 4 percent in operational costs, 5-percent increase in food costs, and 4.3-percent reduction in Federal funds. In 1986 the following reductions in meal levels will be required, according to plans submitted by the Area Agencies on Aging in Maryland:

Area agency:	*Meals*
Anne Arundel County	8,000
Carroll County	3,500
Washington County	6,396
MAC, Inc.	12,975
Calvert County	2,000
St. Mary's County	17,621
Baltimore City	70,000
Upper Shore Aging	8,250
Garrett County	16,258
Total	145,000

On the Lower Shore, served by MAC, Inc., Area Agency on Aging, service to the poor, frail, and minority population continues to dwindle due to insufficient funds. The following are estimated costs to return to more adequate service levels:

	Cost	Meals
Dorchester County	$145,538	32,592
Somerset County	114,613	21,840
Wicomico County	159,351	34,580
Worcester County	49,658	14,560
Total	469,160	103,572

Garrett County sites serve very frail, elderly people who are further handicapped by absence of public transportation. Additional costs to resume more adequate service are estimated at $140,000 per year.

Question. It is my understanding that the Maryland Governor's Task Force on Food and Nutrition Interim Report recommended that Maryland request participation in the CSEP for elderly. Do you believe this program would be an integral component of the continuum of long-term care to prevent institutionalization of the elderly?

Answer. The Maryland Governor's Task Force on Food and Nutrition Interim Report recommended that Maryland request participation in the Commodity Special Food Program for the Elderly. As a result of this recommendation, a resolution was passed by the legislature and a study group formed to consider the possibilities of establishing this program in Maryland.

This program could be an integral part of the continuum of long-term care to prevent institutionalization of the elderly. However, for the frail elderly who lack the desire to prepare their own food and eat along, the Congregate Nutrition Program offers strong incentive for improved socialization as well as nutrition.

[The prepared statement of Ms. Abrams appears at the conclusion of the hearing, see p. 87.]

Mr. PANETTA. Thank you. Your statement will be made part of the record.

Mr. Suzuki.

STATEMENT OF MICHIO SUZUKI, ASSOCIATE COMMISSIONER, OFFICE OF STATE AND TRIBAL PROGRAMS, ADMINISTRATION ON AGING

Mr. SUZUKI. Yes, Mr. Chairman. I have submitted a statement for the record. What I will do is just highlight a couple of points then, in terms of the time of the day here.

I am pleased to be here today to discuss the Administration on Aging's Nutrition Program as part of the hearing on Hunger and the Elderly.

Since it was instituted in 1972 the nutrition program for the elderly under the Older Americans Act, has been a favorite program with the older population, and they have been actively participating as consumers, as workers, as volunteers, and as advisers. The program has grown so that in fiscal year 1985 2.9 million older persons were served in the Congregate Nutrition Program, and 693,000 elderly persons were served in the Home Delivered Meals Program.

In fiscal year 1985 we served 150 million congregate meals, and 75 million home-delivered meals, or a total of 225 million meals in this last fiscal year. That's a growth that has been steadily growing over the years.

A mandate that we have worked under has been to target resources to those older persons in greatest social or economic need, and to those vulnerable elderly most in danger of losing their independence. The Older Americans Act requires that we assure the

preference be given to older persons with greatest social or economic need, but we also are required to avoid the use of a means test for eligibility for our services, particularly our nutrition programs.

Our preliminary data for fiscal year 1985 indicate that 53 percent of the people served in our Congregate Nutrition Program were low income at the poverty level or below. Of those participating in our nutrition program, 17-percent were minorities, that is, the Congregate Nutrition Programs.

Home delivered nutrition programs are even more oriented toward the needy with 66 percent of the home-delivered meals going to low income, and 19 percent of our program of home delivered meals going to minorities.

It should be pointed out that with the passage of years more and more of our resources are being targeted toward the homebound. An analysis of the title III expenditure data shows that most States are transferring funds out of the C-1 Congregate Meal Programs and into the home-delivered meals and supportive services category. There's a typo in our prepared statement. It says that in fiscal year 1985 home-delivered C-2 expenditures were increased by 3.7. It shouldn't be a decimal point. It was increased by 37 percent.

In other words, out of the Congregate Meal Program, States at their option have transferred over $46 million out of the Congregates Meals Program nationally, half of that going to supportive services, and half of it going to home-delivered meals. So that's the program that is expanding, particularly at the option of the States in terms of their diverting the resources.

I think I will just summarize by saying that the studies that we have undertaken indicate clearly that the meals program, nutrition program, has been supplying the required one-third daily allowances, and it has been an important part in maintaining the health of the elderly population in the United States.

The program has been emphasizing nutritional quality, nutrition education, and health promotion, and we feel that the network, the State agencies, and the area agencies, and the providers, have been performing an outstanding service to this country, and to the elderly population.

I'd be pleased to answer any questions you might have, Mr. Chairman.

RESPONSES TO QUESTIONS FOR MICHIO SUZUKI

QUESTIONS SUBMITTED BY HON. LEON PANETTA

Question. What percentage of the eligible low-income elderly population receives congregate or home-delivered meals?

Answer. As you know, there are no income eligibility requirements for older persons to participate in a congregate or home-delivered nutrition services program. State and area agencies, however, are required to give priority to serving those older persons in greatest social or economic need and do so by targetting limited title III resources to those services and geographic areas with high concentrations of low-income elderly. In fiscal year 1985, State agencies reported that 53-percent of the persons receiving congregate nutrition services and 66-percent of persons receiving home-delivered meals had incomes at or below poverty level.

Question. It is expected that there will be a vast increase in the elderly, homebound population. How does the Department plan to respond to what will certainly continue to be a growing need for nutrition and support services for this group?

Answer. We will continue to give emphasis to improving the linkage of service systems at the community level to help assure that those systems, especially ones

that are designed to address the needs of the most vulnerable elderly—those in greatest risk of institutionalization, are truly responsive to the needs of this population. Area agencies have a unique and critical responsibility in this area: They are the brokers and catalysts in the community who help to bring together the various components of the continuum of care in the community to see that older persons do not slip through the cracks, and that they remain in the community as long as possible. Through effective use of our discretionary resources in demonstration and training projects, and sharing effective approaches to community systems development with State and area agencies, we believe we can help area agencies become more effective in making those systems more responsive to older persons and their families.

Question. Mr. Moyers stated that individual meal providers are unable to receive bonus commodities unless the State receives more than 50-percent of its reimbursements per meal in the form of commodities. Why are DHHS and USDA not making these bonus commodities available to all providers who can use them?

Answer. Distribution of bonus commodities to eligible recipient agencies is the responsibility of the USDA through the State distributing agency system. Information about specific foods and amounts is available from that Department.

As we understand USDA general memorandum #387, nutrition programs, including those receiving cash in lieu of USDA food are eligible to receive bonus foods to the extent that they can be used without waste. Rice is an exception. Projects receiving less that 50-percent of entitlement in commodities are not eligible to receive rice and possibly beef as a bonus.

Question. What kind of planning is the Department conducting to consider the potential cost savings of nutrition services versus institutionalization and medical care?

Answer. I am unaware of any planning by the Department to consider the cost savings of nutrition services in comparison to the costs of institutionalization and medical care.

Question. Do you have any recommendations for expanding the use of commodities for elderly nutrition programs?

Answer. We consistently encourage all nutrition service providers to operate in an efficient manner that maximizes all available resources. This would include the appropriate use of commodities. We also have under consideration a proposal which, in part, would serve to enhance awareness of USDA resources including bonus foods and national commodity processing. With additional information, we believe that State agencies may wish to reevaluate the cost effective use of USDA food rather than cash reimbursement for meals served and to consider how the food delivery system can be improved to increase the number of meals served.

[The prepared statement of Mr. Suzuki appears at the conclusion of the hearing, see p. 97.]

Mr. PANETTA. Thank you very much for your testimony. As you've heard, there's a vote that we have on now. There's probably about 6 minutes remaining, so I'm going to have to go to that vote.

Rather than holding you up, I'm going to thank you for the testimony that you presented. All of it will be made part of the record. I hope we can come back to each of you if we have any additional questions among the members, I know in terms of my work, and we will be making another effort at trying to develop a hunger relief bill this year. Again, that I will be using the resources you provided here to try to direct some of these programs, particularly at the elderly, if we can, because that is an area that I think that we've ignored, and it's time that we face it because it really does relate to the cost-effectiveness that you've pointed out, Senator Abrams.

So thank you all for your testimony. The hearing is now adjourned.

[Whereupon, at 5:30 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

U.S. House of Representatives
DOMESTIC TASK FORCE
SELECT COMMITTEE ON HUNGER
Room 442-507, House Office Building, Annex No. 2
Washington, DC 20515

JOINT HEARING OF HOUSE SELECT COMMITTEES ON HUNGER AND AGING

"HUNGER AND THE ELDERLY"

INCREASING NUMBER OF ELDERLY

During the last two decades, the 65 and older population grew by 54 percent -- more than twice as fast as the rest of the population. This growth, particularly among the elderly aged 75 and older, is projected to be even greater over the next two decades and beyond.

POVERTY LINKED TO HUNGER AMONG THE ELDERLY

Poverty may be one of the most important environmental determinants of inadequate nutrition among the elderly. Many poor elderly live on **fixed incomes**, have **activity limitations** and have **health problems** necessitating special diets. As a result, poor households headed by senior citizens spend 40 percent of their income for food compared with about 33 percent for other households.

POVERTY STATISTICS

Elderly persons are more likely than other adults to be poor. In 1984, 12.4 percent of persons 65 and older (3.3 million persons) had incomes below poverty, compared to 11.7 percent of those age 18 to 64.

The elderly are much more likely to be "near poor" than the rest of the population. In 1984, 16.7 percent of persons aged 65 and older were in families with incomes between 100 and 150 percent of the poverty level compared to only 9.1 percent of those under age 65 whose family incomes fell within this range.

Minority Elderly: In 1984 the poverty rate among the black elderly was 31.7 percent; among the Hispanic elderly it was 21.5 percent.

The Oldest Elderly: Adults age 75 and older make up 40 percent of the elderly. **In 1984 over one-third (34.3 percent) of women age 85+ were poor or within 125 percent of poverty.** These individuals are at great risk of hunger due to their increasing frailty, disabilities and serious medical conditions.

Elderly Living Alone: In 1984, one-third of older(75+), noninstitutionalized elderly persons lived alone. **Poverty rates were highest for elderly black women 75+ living alone, with nearly three out of five (56.6 percent) living in poverty.**

*1984 Poverty level for aged individual = $4,979
1984 poverty level for couple with aged head = $6,510

OTHER FACTORS PLACING ELDERLY AT RISK OF HUNGER

SOCIAL SECURITY AND SSI DO NOT PREVENT ELDERLY POVERTY

While most of the elderly population (94.4 percent) receives Social Security and/or Supplemental Security Income (SSI) benefits, these benefits do not protect against poverty:

--12.3 percent of poor families with an elderly head do not receive Social Security;

--Social Security benefits for retired minimum wage earners do not bring them up to poverty (sample benefits = $4,560 annually);

-- As of January, 1986 the maximum annual potential Federal SSI and food stamp benefits for elderly individuals with no income, living

independently, totals $4,656. Including State supplemental SSI income (not provided for elderly in 7 states*), these total benefits do not bring elderly individuals without income up to the poverty level in 36 States.

CHRONIC MOBILITY LIMITATIONS

Among the poor elderly 53% are chronically limited in their activity and thus may need assistance in shopping, preparing meals and/or eating.

ELDERLY PAY HIGH OUT OF POCKET MEDICAL EXPENSES

Despite extensive Medicare and Medicaid coverage for the elderly, direct out-of-pocket health care expenses for the elderly averaged $1,059 per person in 1984--the cost of services and aids not covered by any insurance. **(Note that this amount is at least one-fifth of the total income of a single older adult living in poverty.)**

DRGs INCREASE NEED FOR HOME-DELIVERED MEALS

Recent Medicare reform legislation requires that hospitals be reimbused based upon diagnosis-related groups (DRG's). This prospective payment system has resulted in earlier hospital discharge of the elderly. Area Agencies on Aging report that since the implementation of the DRGs the demand for home delivered meals has increased significantly because many of those released earlier from hospitals need intensive nutrition assistance at home.

NUTRITION SURVEYS REVEAL UNDERNUTRITION AMONG THE ELDERLY

The Acting Associate Director of USDA's Human Nutrition Research Center on Aging reports:

> "Nutritional surveys have revealed that substantial numbers of the elderly are seriously lacking in particular nutrients. In some studies over half the respondents failed to meet the recommended level of calories and two-thirds have less than than adequate calcium intakes....Dietary quality becomes very difficult to assure when overall (calorie) intake is low..."

*States not providing supplemental SSI benefits are Arkansas, Georgia, Kansas, Mississippi, Tennessee, Texas and West Virginia.

FEDERAL FOOD AND NUTRITION PROGRAMS TARGETTED TO THE ELDERLY

NUTRITION SERVICES FOR THE ELDERLY

Nutrition Services for the elderly, originally authorized as Title VII of the Older Americans Act in 1972 and changed in 1978 to Title III-C, provide funds to States to deliver nutritionally balanced meals to the elderly. Meals are provided either in a congregate dining setting (Title III C-1) such as a senior citizen center, a church or a school or through the provision of home-delivered meals to the homebound (Title III C-2). The program is administered by the Department of Health and Human Services (DHHS), Office on Aging with per-meal cash and/or commodity reimbursements administered by the US Department of Agriculture(USDA).

The programs are open to all persons 60 years of age or older, regardless of income. However, Federal regulations emphasize that the poor, ethnic minorities, the socially isolated and the handicapped be given priority enrollment. In fiscal year '85 there were approximately 9,000 nutrition projects around the U.S. providing 225 million meals to elderly persons. Federal funding is supplemented by voluntary contributions from program participants. States, providing supplemental funding to serve more of the elderly in need include Texas, New York, California, Maryland, Kansas.

A recent national evaluation of the elderly meal programs found they meet their legislative intent of fostering social interaction, facilitating the delivery of other social services, and that they significantly improve the diet of participants. An

earlier DHHS study found that the home-delivered meals program helps participants continue to function in their communities and avoid nursing homes.

THE COMMODITY SUPPLEMENTAL FOOD PROGRAM FOR THE ELDERLY

A smaller but significant program of nutrition assistance to the elderly is included in the Commodity Supplemental Food Program (CSFP), adminstered by USDA. Beginning in September 1982 as pilot projects expanding upon the CSFP for women, infants and children, this program provides commodites, in surplus or purchased by USDA, for home preparation by the elderly. Pilot projects were conducted in three cities (Detroit, Des Moines and New Orleans). Participants pick up food packages if they are mobile, provide home deliveries if they are homebound, transportation assistance and referral to other social services as needed. These programs rely primarily on volunteers.

The Food Security Act of 1985 extends the authority for these programs for four more years at no less than the FY 85 caseload (approximately 19,500) and authorizes the expansion of CSFP to serve elderly in other areas, provided that the increase in elderly served does not terminate or reduce assistance to eligible women, infants and children.

FUNDING REDUCTIONS IN ELDERLY NUTRITION PROGRAMS

RECENT FEDERAL FUNDING FOR TITLE III C ELDERLY NUTRITION SERVICES

	FY '84	FY '85	FY '86
DHHS APPROPRIATIONS (in thousands of dollars)			
Congregate Meals	$321,574	$336,000	$321,522*
Home Delivered Meals	$67,025	$67,900	$64,980*
USDA CASH OR COMMODITY REIMBURSEMENT PER MEAL SERVED (in cents)	56.5	53.61**	53.12**

The Elderly Nutrition Services are the only major nutrition programs not exempted from sequestration under Gramm-Rudman-Hollings.

*This figure represents the FY 1986 appropriations minus the $.3 million reduction enacted by Sec. 515 of the Agriculture Appropriations Act and the $14,448,000 reduction resulting from Gramm-Rudman-Hollings.

**These rates were used by USDA's Food and Nutrition Service to determine the 1987 budget request. Recent legislation increasing the authorization levels may result in a slight adjustment in the reimbursement rate. USDA does not yet have a new offical estimate of the reimbursement rate for FY '85 or FY '86. Existing appropriations available for 1985 and 1986, however, are insufficient to maintain the 56.76 reimbursement rate intended by Congress in the legislation providing an increase in the authorization.

UNMET NEED FOR FOOD AND NUTRITION SERVICES TO THE ELDERLY

FOOD STAMPS

The food stamp participation rate is very low among households headed by the elderly poor. 69 percent of elderly poor in families do

not receive food stamps and nearly three out of four (71 percent) of unrelated elderly poor do not receive food stamps.

According to a study conducted for the US Department of Agriculture in 1982, over two-thirds (69 percent) of the elderly eligible but not participating in the Food Stamp Program believe they are not eligible or do not know they are eligible.

HOME-DELIVERED MEALS

Texas State Office on Aging reports an unmet need of 16,000. By September, 1986 an additional 2,000 elderly will be dropped from the home-delivered meals services covered by Title XX funds.

Maryland State Office on Aging reports that 28,000 homebound needy elderly are unserved by elderly nutrition services and in need. The Office states that Maryland population shifts indicate the need will continue to grow.

Texas and Florida report that funds that would normally be used to remove more homebound elderly from the waiting list must be used now for the increase in home-delivered meal services to patients released earlier from hospital care as a result of the DRGs.

ELDERLY CSFP

Des Moines - 600 on waiting list (program provides no public information or outreach for their services to limit the waiting list)

New Orleans - 3,000 on waiting list

Detroit - 15,000 on waiting list

U.S. House of Representatives

SELECT COMMITTEE ON HUNGER

ROOM H2-807, HOUSE OFFICE BUILDING, ANNEX NO. 2

WASHINGTON, DC 20515

February 24, 1986

Dear Colleague:

Recently a new year-long advertising campaign was launched by the Advertising Council to provide public information about eligibility for the Federal Food Stamp Program. The campaign includes 1-minute and 30-second radio and television spots to be aired on national and local communication networks depicting the theme: "Mealtimes Don't Have to Be Tough Times."

The idea for this ad campaign was developed by John Driggs, a member of President Reagan's 1983 Task Force on Food Assistance. As part of the Task Force's work, Mr. Driggs became aware that many American families confronting financial hardship may be eligible for food stamps, but they do not know it.

Mr. Driggs convinced the Advertising Council, a voluntary board comprised of U.S. advertising agencies, to commit its talent and resources to help. The Food Stamp Program public information project was selected among several worthwhile projects for a year-long promotion by the Ad Council. You may be familiar with similar voluntary public service announcements the Ad Council has developed in recent years, such as "Take a Bite Out of Crime," "Smokey says: Only You Can Prevent Forest Fires," and "The Toughest Job You'll Ever Love" for the Peace Corps.

This campaign has the support of the U.S. Department of Agriculture. However, the ad campaign is not supported by Federal tax dollars; its expenses are paid entirely through private donations.

As the Ad Council broadcasts of "Mealtimes Don't Have to Be Tough Times" are aired throughout the year, a toll-free telephone number (1-800-453-4000) will be presented for those who seek information about food stamp eligibility. Each caller providing a name and mailing address will be sent a packet of explanatory information from the Committee on Food and Shelter, a private non-profit organization in Washington, D.C. (Costs for the printing and preparation of this follow-up information have been paid for by the Pillsbury Company.) In addition, each caller will be given a toll-free number in his own State, where an operator will answer further questions or direct them to a local service office.

You may wish to inform you local district offices of this private sector sponsored ad campaign, should your constituents have questions. A list of toll-free numbers for each State is listed on the reverse side for your reference.

Sincerely,

Mickey Leland
Chairman, Select Committee on Hunger

Leon E. Panetta
Chairman, Task Force on Domestic Hunger

Marge Roukema
Ranking Minority Members, Select Committee on Hunger

Bill Emerson
Ranking Minority Member, Task Force on Domestic Hunger

Food Stamp Information Program

"MEAL TIMES - TOUGH TIMES"

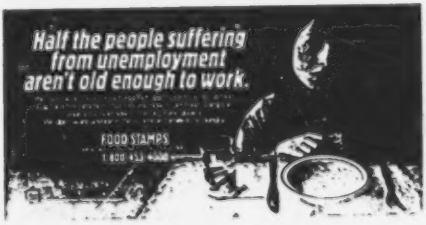
STATE FOOD STAMP INFORMATION NUMBERS

Alabama	1-800-392-8047	Nebraska	402-471-3121
Alaska	465-3360	Nevada	1-800-992-0900
Arizona	1-800-352-8401	New Hampshire	1-800-852-3345
Arkansas	1-800-482-8988	New Jersey	1-800-792-9773
California	1-800-952-5253	New Mexico	1-800-432-6217
Colorado	399-9900	New York	1-800-342-3009
Connecticut	1-800-842-1508	North Carolina	1-800-662-7030
Delaware	1-800-292-7924	North Dakota	1-800-472-2622
District of Columbia	202-727-0858	Ohio	1-800-282-1190
Florida	1-800-342-9274	Oklahoma	1-800-522-8350
Georgia	1-800-282-5808	Oregon *	
Hawaii	548-2236	Pennsylvania	1-800-692-7462
Idaho	334-4337	Rhode Island *	
Illinois	1-800-252-8635	South Carolina	1-800-922-3178
Indiana	1-800-622-4932	South Dakota	1-800-233-8503
Iowa *		Tennessee	1-800-342-1784
Kansas	913-296-2959	Texas	1-800-252-9330
Kentucky	1-800-372-2973	Utah *	
Louisiana	1-800-272-9868	Vermont	1-800-622-4476
Maine	1-800-452-4643	Virgin Islands	
Maryland	1-800-492-0618	Virginia	1-800-552-3431
Massachusetts	1-800-882-1223	Washington *	
Michigan	1-800-521-6221	West Virginia	1-800-642-8589
Minnesota	1-800-652-9747	Wisconsin	1-800-222-7890
Mississippi	1-800-222-7622	Wyoming	777-6083
Missouri	1-800-392-1261		
Montana	1-800-332-2272		

* Iowa - Call the County Department of Human Services
  Rhode Island - Call the local Human Services Office
  Oregon - Call the Adult and Family Services Office
  Utah - Call the Social Services Community Operations Office
  Washington - Call the local Community Services Office

FOR MORE INFORMATION ABOUT THE CAMPAIGN:

Mrs. Meg Graham, President
Committee for Food and Shelter
815 15th Street, NW
Suite 625
Washington, DC 20005



NEWS

Select Committee on Aging

U.S. House of Representatives

EDWARD R. ROYBAL, Chairman
300 New Jersey Ave. S.E. Room 712
Washington, D.C. 20515
202/ 226-3375

FOR IMMEDIATE RELEASE
April 22, 1986

CONTACT: Austin Hogan, Brian Lutz
(202) 226-3373

WIDENING HUNGER AMONG ELDERLY POOR POSES HEALTH THREAT:

JOINT HEARING TO BE HELD TODAY BY COMMITTEES ON HUNGER AND AGING

Arizona Business Leader Outlines Initiatives For Public-Private

"Partnership Approach" To Solve America's Hunger Problem

HUNGER AND THE ELDERLY"
A Joint Hearing of the House Select Committee on Hunger and the House Select Committee on Aging
2:00 P.M., Tuesday, April 22, 1986
Room 311 Cannon House Office Building

WASHINGTON, D.C., APRIL 22 -- Edward R. Roybal (D-CA), Chairman of the House Select Committee on Aging, today will join with Mickey Leland (D-TX) Chairman of the House Select Committee on Hunger, and Leon Panetta (D-CA), Chairman of the Hunger Committee's Domestic Task Force, in co-chairing a joint hearing to examine the problem of hunger and malnourishment among the elderly.

"The hearing will examine compelling evidence which indicates that hunger and malnourishment is growing rapidly among the oldest and most vulnerable of our elderly population," Roybal stated, "and assess the concern among many health professionals and nutrition service providers that these individuals are at severe and increased risk of adverse health problems."

Roybal also indicated his interest in examining the low participation rates of older Americans in federal assistance programs. "Given the important role of the food stamp program in reducing hunger and malnourishment, it is distressing to learn that nearly seven of ten elderly poor in families do not receive food stamps and nearly three of four unrelated elderly poor do not receive this basic nutritional assistance."

"Additionally, many states have found that tens of thousands of the isolated and homebound elderly are currently unserved by nutrition services under the Older Americans Act," Roybal declared. "In Maryland alone, the Office on Aging reports that at least 28,000 homebound elderly do not receive nutrition assistance and that the demand for home delivered meals has increased significantly since the implementation of diagnostic-related groups (DRG's) under the Medicare program."

At the hearing, John Driggs, Chairman of the Board of Western Savings and Loan Association of Arizona, former Mayor of Phoenix, and member of the President's Commission on Hunger, is scheduled to outline an innovative national private sector program he directs through the Advertising Council to provide information and develop a public-private cooperative effort to help solve the problem of hunger in America.

HEARING WITNESSES

Mr. William R. Hutton, Executive Director, National Council of Senior Citizens, Washington, D.C.

Mr. John Driggs, Chairman of the Board, Western Savings and Loan Associations, former Mayor of Phoenix, Arizona and a member of the President's Commission on Hunger.

Mr. Michio Suzuki, Associate Commissioner for the Office of State and Tribal Programs, Administration on Aging, Department of Health and Human Services.

Ms. Adelaide Carpenter, Volunteer, Polk County Elderly Feeding Program, Des Moines, Iowa.

Dr. David Lipschitz, M.D., Ph.D., Director of Geriatric Research Education and Clinical Center, John L. McClellan Memorial Veterans Hospital, Little Rock, Arkansas.

Mr. Bill Moyer, Director, King County Nutrition Project, Seattle, Washington.

Ms. Rosalie Abrams, Director, Maryland Office on Aging, Baltimore, Maryland.

Prepared Statement of Hon. Marge Roukema, a Representative in Congress From the State of New Jersey

GOOD AFTERNOON.

I AM PLEASED TO BE HERE TODAY WITH MY COLLEAGUES FROM BOTH THE HUNGER AND AGING COMMITTEES. IT IS APPROPRIATE THAT WE HOLD A HEARING ON THIS SUBJECT AT THIS TIME, SINCE CONGRESS HAS DESIGNATED MAY AS OLDER AMERICANS MONTH. I AM INTERESTED IN LEARNING HOW FAR WE HAVE COME IN MEETING THE NUTRITIONAL NEEDS OF OUR ELDERLY CITIZENS, AND HOW MUCH FARTHER WE HAVE TO GO.

AS YOU MAY KNOW, ELDERLY AMERICANS ARE THE FASTEST GROWING POPULATION GROUP IN THIS COUNTRY--IN 1980 ABOUT 25.5 MILLION AMERICANS WERE OVER THE AGE OF 65 AND BY THE YEAR 2000 THIS NUMBER WILL DOUBLE. THIS INCREASE WILL HAVE A PROFOUND IMPACT ON THE FUTURE OF OUR COUNTRY AS WE MEET THESE CITIZENS' NEEDS.

ELDERLY AMERICANS MAY BE PARTICULARLY VULNERABLE TO MALNUTRITION BECAUSE OF THEIR ISOLATION AND DECLINING HEALTH STATUS. INADEQUATE NUTRITION MAY RESULT FROM THE SIDE EFFECTS OF DRUGS, LOSS OF TASTE, AND DEPRESSION, AS WELL AS FROM DISEASE AND POVERTY. RECENT STUDIES HAVE SHOWN THAT MALNOURISHMENT MAY CAUSE MUCH OF THE PHYSIOLOGICAL DECLINE IN DISEASE RESISTANCE SEEN IN ELDERLY PATIENTS. THEREFORE, IN ORDER TO ENSURE LONGER AND HEALTHIER LIVES OF THE EVER INCREASING ELDERLY POPULATION, WE MUST CONTINUE TO ADDRESS THE PROBLEM OF ELDERLY MALNUTRITION.

THE OLDER AMERICANS ACT OF 1965, AS AMENDED, IS THE CENTERPIECE FOR THE ORGANIZATION AND DELIVERY OF SERVICES TO THIS IMPORTANT GROUP OF CITIZENS. IN ORDER TO SPECIFICALLY MEET THE NUTRITIONAL NEEDS OF THE ELDERLY, CONGREGATE AND HOME-DELIVERED MEAL PROGRAMS ARE AUTHORIZED UNDER THIS ACT. IN FISCAL YEAR 1984, CONGRESS APPROPRIATED $367.3 FOR THESE PROGRAMS WHICH ALLOWED STATE AND LOCAL AGENCIES TO SERVE APPROXIMATELY 212 MILLION MEALS TO 3.2 MILLION OLDER PERSONS. TODAY WE WILL HEAR FROM A REPRESENTATIVE OF THE THE ADMINISTRATION ON AGING ABOUT THESE PROGRAMS.

IN ADDITION, THERE ARE OTHER NUTRITION PROGRAMS THROUGH WHICH THE

ELDERLY BENEFIT, INCLUDING THE FOOD STAMP PROGRAM, THE COMMODITY SUPPLEMENTAL FOOD PROGRAM, AND COMMODITY DISTRIBUTION TO CHARITABLE INSTITUTIONS. TODAY'S WITNESSES WILL PROVIDE US WITH INSIGHT INTO THESE PROGRAMS.

WE CAN BE PROUD OF OUR ACHIEVEMENTS BECAUSE, AS A GROUP, THE ELDERLY HAVE COME A LONG WAY. BEING OLD NO LONGER IS NECESSARILY EQUATED WITH BEING POOR OR HUNGRY. BUT, WE CANNOT REST ON OUR LAURELS. THE PRESIDENT'S TASK FORCE ON FOOD ASSISTANCE FOUND THAT MANY POTENTIALLY ELIGIBLE ELDERLY PERSONS DO NOT PARTICIPATE IN THE FOOD STAMP OR ELDERLY FEEDING PROGRAMS. WE ALSO OFTEN HEAR OF WAITING LISTS FOR THESE PROGRAMS.

IN THIS TIME OF FISCAL RESTRAINT WE MUST MAKE SURE THAT THE EFFECTIVENESS OF THE IMPORTANT ELDERLY NUTRITION PROGRAMS IS NOT DIMINISHED. I LOOK FOWARD TO TODAY'S TESTIMONY AND RECOMMENDATIONS AND THANK THE WITNESSES FOR THEIR TIME.

Prepared Statement of Hon. Jim Lightfoot, a Representative in Congress From the State of Iowa

CHAIRMAN PANETTA, CHAIRMAN LELAND, AND CHAIRMAN ROYBAL, I COMMEND YOU FOR CALLING THIS HEARING TODAY TO DISCUSS HUNGER AMONG THE ELDERLY. THIS IS AN ISSUE WHICH DESERVES GREATER CONGRESSIONAL ATTENTION BECAUSE OF ITS RAMIFICATIONS ON THE OVERALL HEALTH AND SAFETY OF OLDER AMERICANS.

RECENT STUDIES INDICATE THAT THE WELL-BEING OF SENIOR CITIZENS DEPENDS LARGELY ON AN ADEQUATE AND NUTRITIONALLY-BALANCED DIET. MANY GERONTOLOGISTS AND NUTRITION EXPERTS HAVE FOUND THAT MALNOURISHMENT MAY CAUSE A DRAMATIC DECLINE IN RESISTANCE TO DISEASES WHICH AFFLICT THE ELDERLY. IT HAS BEEN SUGGESTED THAT MANY ILLNESSES AMONG THE ELDERLY CAN BE PREVENTED BY PROVIDING THEM WITH BETTER NUTRITION.

IN MY OWN DISTRICT IN IOWA, WHICH IS THE SECOND MOST RURAL DISTRICT AND THE 27TH MOST ELDERLY DISTRICT IN THE NATION, THE NUTRITIONAL PROBLEMS OF THE RURAL ELDERLY ARE COMPOUNDED BY ISOLATION, LACK OF PUBLIC TRANSPORTATION, AND THE INABILITY TO TAKE ADVANTAGE OF FEDERAL PROGRAMS, SUCH AS THE COMMODITY SUPPLEMENTAL FOOD PROGRAM.

THE NEED FOR GREATER FOOD ASSISTANCE FOR RURAL IOWANS WAS GRAPHICALLY DISPLAYED TO ME LAST YEAR WHEN I SPONSORED A WEEK-LONG FOOD DRIVE. THIS FOOD DRIVE, WHICH HAS BECOME AN ONGOING PROJECT, HAS COLLECTED TENS OF THOUSANDS OF DOLLARS IN FOOD AND PAPER PRODUCTS. VOLUNTEERS DISTRIBUTED THESE PRODUCTS TO FOOD PANTRIES THROUGHOUT THE DISTRICT. IN MY VISITS WITH THE FOOD PANTRY DIRECTORS, THEY COMMENTED THAT THE ELDERLY WERE FREQUENT VISITORS TO THE FOOD PANTRIES. THEY RELIED UPON ASSISTANCE FROM THESE PANTRIES TO HELP MAKE ENDS MEET.

MANY OF THESE OLDER IOWANS WOULD QUALIFY FOR FOOD ASSISTANCE, BUT THEY EITHER ARE UNAWARE THAT THE PROGRAMS EXIST OR ARE RELUCTANT OR UNABLE TO SEEK ASSISTANCE. THE FOOD PROGRAMS WHICH MIGHT BENEFIT THEM ARE FOOD STAMPS, CONGREGATE MEALS, OR MEALS ON WHEELS. UNFORTUNATELY, THESE PROGRAMS DO NOT BENEFIT AS MANY

ELDERLY AS THEY SHOULD, ESPECIALLY THOSE LOCATED IN THE MORE RURAL AREAS WHERE THERE MIGHT NOT BE A CONGREGATE MEAL SITE OR A MEALS ON WHEELS PROGRAM.

ONE AREA THAT NEEDS GREATER ATTENTION IN CONGRESS IS INCREASING THE AWARENESS OF THESE PROGRAMS AMONG THE ELDERLY AND ENCOURAGING THOSE ELIGIBLE FOR THEM TO PARTICIPATE IN THEM. IT IS ALSO IMPORTANT THAT GREATER EFFORTS BE MADE TO EDUCATE ALL OLDER AMERICANS ON THE BENEFITS OF PROPER NUTRITION AND DIET. IN THE LONG RUN, IT WILL IMPROVE THE HEALTH AND WELL-BEING OF ALL OLDER AMERICANS.

Prepared Statement of Hon. Bill Emerson, a Representative in Congress From the State of Missouri

Today's hearing focuses on the elderly population and how they are assisted by the various Federal assistance programs. I will discuss the food stamp program and some of the special provisions that are a part of that program aimed at helping the elderly

1. The income eligibility standard for the food stamp program is that net income, after certain deductions cannot exceed 100% of the poverty line ($438/month for one person). This provision allows some elderly applicants to have income above the regular program limits and participate in the food stamp program.
2. Food stamp households containing elderly participants have available all deductions allowed under the program. In addition, these households are provided a medical deduction and an unlimited shelter deduction.
3. The asset limit is higher for those households containing an elderly person. Beginning May 1, 1986 the limit is $3000 as opposed to a $2000 limit for all other households.
4. The elderly food stamp participants can use food stamps to pay for meals in authorized restaurants. Fourteen states participated in this facet of the food stamp program in 1984. Food stamps can also be used in communal dining facilities and in small group homes for SSI recipients.
5. Several states provide cash in lieu of food stamps for elderly participants.

In addition, the 1985 Farm Bill required that states grant automatic eligibility for food stamps to those households containing SSI recipients. Moreover, the Farm Bill also required that SSI applicants and recipients are to be informed and helped in making food stamp applications at Social Security offices - expanding these current provisions.

As you can see the Food Stamp Act has indentified the elderly applicants and participants as a group in need of food assistance and provided special rules to assist them in obtaining help.

Thank you Mr. Chairman.

PREPARED STATEMENT OF HON. MATTHEW J. RINALDO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Thank you, Mr. Chairman. I applaud your leadership on this pressing issue and I am pleased to join my colleagues from the Hunger Committee at this hearing today.

Hunger among our nation's elderly is an important issue. Because of the close links between nutrition and illness, nutritional problems among the elderly have many consequences. However, diet is an easily controlable factor and -- in some instances -- can significantly improve the wellness of

For being such an easily correctedable problem, the statistics on this condition are appalling. It has been said that up to 50% of older Americans consume too few calories or other nutrients for good health.
I have been told that the number may run up to 80% in skilled nursing facilities.

This is clearly something that is avoidable and preventable. For those who present special health risks, nutritional problems can be insidious, being mistaken for other medical problems and never being treated properly.

Mr. Chairman, some of the

nutritional problems of our elderly lie in their pride of not asking for help; some of the problems lie with the inaccessibility of the program or the complexity of the application process; and some of the problems can be laid on our doorstep -- the Federal government and the Congress -- for design and inadequate funding levels.

No matter what the problem is, one thing is clear -- Congress must address this problem. This hearing is just one step in the continuing process of ensuring an adequate and nutritious diet for our elderly.

A proposal being developed by Representative Emerson and my Republican colleagues on the Hunger Committee is a step in the right direction. It would create a "one-stop shopping" concept where the elderly could apply and correspond with only one office for all assistance programs rather than having to visit numerous offices for complementary benefits.

Mr. Chairman, I am pleased to be here today and look forward to the testimony of our witnesses. Thank you.

Prepared Statement of Hon. John Paul Hammerschmidt, a Representative in Congress From the State of Arkansas

BASED ON EARLIER WORK OF THE SELECT COMMITTEE ON AGING, IT IS CLEAR THAT PROPER NUTRITION IS ONE OF THE MOST EFFECTIVE MEANS OF MAINTAINING GOOD HEALTH AND MINIMIZING DEGENERATIVE CONDITIONS LATER IN LIFE. A NUTRITIOUS DIET IS ALSO NECESSARY FOR OLDER PERSONS SO THAT THEY CAN RETAIN THEIR CAPACITY FOR ACTIVE AND PRODUCTIVE LIVES. IT IS PAINFUL TO ACKNOWLEDGE THAT AS SUCCESSFUL AS THIS NATION HAS BEEN IN RAISING THE STANDARD OF LIVING FOR THE MAJORITY OF ITS OLDER CITIZENS, THERE ARE STILL PEOPLE WHO ARE HUNGRY IN THIS COUNTRY.

THERE IS ANOTHER GROUP OF PEOPLE WHOSE PROBLEMS ARE LESS VISIBLE BUT WHO ARE ALSO AT RISK -- THOSE WHO SUFFER FROM MALNUTRITION BECAUSE THEY CANNOT AFFORD THE PROPER DIET. THE MAJOR FEDERAL PROGRAM THAT IS AVAILABLE TO COMBAT THESE PROBLEMS IS THE FOOD STAMP PROGRAM. BUT AS I UNDERSTAND IT, ABOUT SEVENTY PERCENT OF THE ELDERLY WHO ARE ELIGIBLE DON'T PARTICIPATE BECAUSE THEY ARE UNAWARE OF THEIR ELIGIBILITY OR FEEL IT IS DEMEANING TO USE FOOD STAMPS.

THERE IS A NEW AND VERY EXCITING CAMPAIGN UNDERWAY WHOSE OBJECTIVE IS TO INCREASE PEOPLE'S KNOWLEDGE OF THE FOOD STAMP PROGRAM AND TO DIMINISH ANY STIGMA ATTACHED TO IT. THIS NEW IDEA WAS INITIATED BY JOHN DRIGGS, THE FORMER MAYOR OF PHOENIX, ARIZONA, WHO SERVED ON THE PRESIDENT'S COMMISSION ON HUNGER IN 1983. AFTER THE COMMISSION FILED ITS REPORT, HE CONTACTED THE ADVERTISING COUNCIL AND ASKED THEM TO UNDERTAKE A CAMPAIGN WHICH WOULD HELP IDENTIFY PEOPLE WHO WERE ELIGIBLE FOR FOOD STAMPS BUT DIDN'T KNOW IT. HE ALSO WANTED TO ELIMINATE THE STIGMA WHICH PREVENTS MANY OLDER PEOPLE FROM USING FOOD STAMPS. THE BOARD OF DIRECTORS OF THE ADVERTISING COUNCIL ACCEPTED HIS PROPOSAL. WORKING WITH A VOLUNTEER ADVERTISING AGENCY AND THE DEPARTMENT OF AGRICULTURE, THEY CREATED THE EXCELLENT PUBLIC SERVICE ANNOUNCEMENTS NOW SEEN ON TELEVISION. EACH ANNOUNCEMENT INCLUDES AN 800 PHONE NUMBER THAT ENABLES PEOPLE TO APPLY FOR ASSISTANCE AT THEIR LOCAL FOOD STAMP OFFICE. WHEN THE CAMPAIGN IS COMPLETED IT WILL HAVE HAD $20 MILLION WORTH OF FREE AIR TIME AND SPACE IN PUBLICATIONS. WHEN MR. DRIGGS ANNOUNCED THE OPENING OF THE

CAMPAIGN ON THE TODAY SHOW. LAST MONTH, 10,000 PHONE CALLS WERE RECEIVED ON THE 800 NUMBER.

BECAUSE I ALSO HAVE THE PRIVILEGE OF SERVING ON THE COMMITTEE ON VETERANS AFFAIRS, I'D LIKE TO WELCOME DR. DAVID LIPSCHITZ, M.D., Ph.D., WHO HAS SERVED FOR THREE YEARS AS THE DIRECTOR OF THE GERIATRIC RESEARCH EDUCATION AND CLINICAL CENTER AT THE JOHN L. McCLELLAN MEMORIAL VETERANS HOSPITAL IN MY OWN STATE OF ARKANSAS. HE IS ALSO HEAD OF THE DIVISION ON AGING AT THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES. HE STILL WORKS ON A DAY TO DAY BASIS WITH ELDERLY PATIENTS WHO HAVE NUTRITION RELATED DISORDERS. HE IS A NATIONALLY ACCLAIMED AUTHOR ON NUTRITIONAL PROBLEMS AND AGING. HE ALSO SERVES ON A VARIETY OF STATE AND NATIONAL MEDICAL COMMITTEES. DR. LIPSCHITZ, WE ARE SO PLEASED THAT YOU COULD TAKE TIME FROM YOUR VERY DEMANDING SCHEDULE TO BE WITH US TODAY.

PREPARED STATEMENT OF HON. HELEN DELICH BENTLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman:

I would like to complement you on having this hearing on "Hunger and the Elderly."

Hunger is a real problem. — Moreover, when we speak of hunger in the world, we don't have to look to underdeveloped third world countries, we can look in our own back yards. Thousands of elderly are suffering from inadequate nutrition here in the United States.

The testimonies we are hearing today will give us many facts and figures that need serious consideration by this committee.

I look forward to the testimony we will be receiving through out this hearing. In specific, I would like to personally welcome Rosalie Abrams, the Director of Maryland State Office on Aging, and a long time friend of mine. I commend her for coming here today to testify and add her expert knowledge to our investigation.

Prepared Statement of Hon. Tom Tauke, a Representative in Congress From the State of Iowa

I COMMEND THE CO-CHAIRMEN FOR CONVENING THIS HEARING TO DISCUSS OUR GROWING CONCERNS FOR THE NUTRITIONAL WELL-BEING OF THE ELDERLY. I AM ALSO PLEASED TO JOIN MY COLLEAGUE, JIM LIGHTFOOT IN WELCOMING ADELAIDE CARPENTER OF COON RAPIDS, TO WASHINGTON. JIM AND I RECOGNIZE THE TREMENDOUS CONTRIBUTIONS MRS. CARPENTER HAS MADE TO THE ELDERLY IN POLK COUNTY BY DISTRIBUTING FOOD TO THE RURAL ELDERLY THROUGH THE COMMODITY SUPPLEMENTAL FOOD PROGRAM. HER KNOWLEDGE AND EXPERIENCE WILL UNDOUBTEDLY PROVIDE BOTH SELECT COMMITTEES VALUABLE INSIGHT OF THE NUTRITIONAL NEEDS OF THE RURAL ELDERLY, IN PARTICULAR.

THE PROGRAM WHICH MRS. CARPENTER CURRENTLY VOLUNTEERS FOR, THE COMMODITY SUPPLEMENTAL FOOD PROGRAM, WAS INITIALLY DESIGNED TO SUPPLY LOW-INCOME YOUNG CHILDREN AND PREGNANT WOMEN WITH NUTRITIONAL SUPPLEMENTS TO THEIR DIETS. THREE ELDERLY FEEDING PILOT PROJECTS WERE LAUNCHED IN 1982 TO EXPAND THIS PROGRAM TO THE ELDERLY INCLUDING ONE IN DES MOINES, IOWA. OUR EXPERIENCE IN THE STATE OF IOWA HAS BEEN QUITE FAVORABLE, PROVIDING NUTRITIONAL FOOD FOR 4,100 ELDERLY IOWANS (OVER 500 ARE ON A WAITING LIST), AND I WOULD ENCOURAGE BROADENING THE AVAILABILITY OF OUR SURPLUS FOODS TO SENIOR CITIZENS.

JUST AS THIS PROGRAM FOCUSES ON THE NUTRITIONAL NEEDS OF THE VERY YOUNG AND THE ELDERLY, I HOPE OUR DISCUSSION TODAY CAN LOOK TOWARD RAISING PUBLIC AWARENESS OF THE EXISTING MEAL PROGRAMS AVAILABLE TO SENIOR CITIZENS FROM OLDER AMERICANS ACT MEAL PROGRAMS, THE FOOD STAMP PROGRAM, AND THE COMMODITY SUPPLEMENTAL FOOD PROGRAM. WE MUST ALSO ENCOURAGE HEALTH CARE PROVIDERS TO EDUCATE RECOOPERATING SENIORS OF THE VITAL IMPORTANCE OF MAINTAINING AND SUPPLEMENTING THEIR DIETARY HABITS IN ORDER TO RECOVER MORE QUICKLY AND MORE FULLY. THE GROWTH OF WELLNESS PROGRAMS AND HOLISTIC CARE CAN ALSO ASSIST OUR ELDERLY POPULATION TO MAINTAIN THEIR HEALTH THROUGH PROPER EATING HABITS.

WE MUST NOT ONLY EDUCATE THE PUBLIC OF EXISTING PROGRAMS BUT TARGET OUR CAMPAIGN TO THOSE WHO ARE IN THE MOST NEED. CONSIDERING THAT MANY SENIORS LIVE ON FIXED INCOMES AND MUST STRETCH EACH DOLLAR TO BE ABLE TO PAY FOR HOUSING, MEDICAL CARE, PRESCRIPTION DRUGS, ETC., EDUCATION ON METHODS OF ENSURING A HEALTHY DIET ON LIMITED MEANS IS NECESSARY.

OUR ELDERLY, PARTICULARLY THOSE NEAR AND IN POVERTY, ARE MOST SUSCEPTIBLE TO SUFFER FROM MALNUTRITION AND HUNGER. WE CAN WIN THE BATTLE AGAINST HUNGER AND IMPROVE THE HEALTH OF SENIORS BY EXPANDING THEIR KNOWLEDGE OF AVAILABLE GOVERNMENT ASSISTANCE PROGRAMS AND THEIR KNOWLEDGE OF NUTRITIONAL NECESSITIES.

I LOOK FORWARD TO LEARNING THE VIEWS OF OUR DISTINGUISHED WITNESSES TODAY AND HOPE WE FIND VIABLE SOLUTIONS TO THE PROBLEM OF HUNGER AMONG THE ELDERLY.

PREPARED STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Chairmen Leland and Roybal, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. The National Council represents 4.5 million older persons, many of whom participate in Federal nutrition programs. We are glad the Select Committees on Hunger and Aging have joined forces to examine the problem of hunger among the elderly. There has been very little attention devoted to this issue, although hunger and malnutrition afflict many older persons and poor nutrition can adversely affect health maintenance.

We welcome the opportunity to address this important subject. It is a disgrace for any person to go hungry in a country with the abundant resources of the United States. It is also short-sighted and ineffective social policy to fail to ensure adequate nutrition for our citizens and later pay higher costs for health care.

In recent months, there have been numerous media portrayals of the elderly as being uniformly wealthy. Some have even implied that the "wealthy elderly" are the source of many of our nation's economic woes. Today's hearing provides a much-needed opportunity to refute such distortions.

An unacceptably large number of older persons remain in poverty today. Their needs must not be ignored simply because some of the elderly are affluent. Furthermore, medical studies reported last year indicate that malnutrition may be far more pervasive among the aged than previously realized.

According to "The New York Times," as many as half the nation's elderly may be consuming too few calories, proteins or essential vitamins and minerals for good health. The resultant poor nourishment may be contributing to the weakened disease resistance seen among the elderly, scientists report. These problems afflict even the affluent elderly, although they are more serious among the poor.

As a nation, we face the challenge of an aging society. It is imperative that policy decisions affecting the elderly be made with a recognition of the diversity of the aging population and a sensitivity to the needs of the vulnerable.

Why is There Hunger Among the Elderly?

Most Americans who experience hunger or malnutrition do so for

purely economic reasons. The causes are far more complex among the elderly population. Among the factors which may contribute to poor nutrition among the aged are: chronic illness, diminished ability to absorb nutrients from food, loneliness, and difficulty in shopping for food and preparing meals. Lack of income will exacerbate any of these problems and, therefore, must be given special attention.

Although the aged are no longer the poorest group of Americans, there are still substantial numbers of older persons in or perilously close to poverty. The link between poverty and risk of inadequate nutrition is clear.

The development of the poverty line was based upon a diet plan designed only for short-term use. Then, a lower poverty standard was established for the elderly, based on the assumption that older people need less food than do younger persons. This threshold is over $400 a year lower for elderly individuals, $700 lower for aged couples, than for the non-elderly. But while the elderly require fewer calories, their nutritional needs do not diminish. The leading specialist on nutrition and aging, Dr. Robert Butler, recommended an income 25 percent above the official poverty line to provide a nutritionally adequate diet for the elderly.

Using that standard, nearly 5.7 million persons aged 65 and over may be at nutritional risk. This constitutes 21 percent of the nation's elderly. Certain subgroups of the elderly are far more likely to be poor and consequently risk hunger: women, minorities, persons living alone and the very old. As the following chart indicates, poverty rates among subgroups vary widely.

1984 Poverty Rates (Percent)

	Total	White	Black	Hispanic
Men 65+	8.7	7.2	25.9	20.6
Women 65+	15.0	13.1	35.6	22.1
Total 65+	12.4	10.7	31.7	21.5
65+ Below 125% of Poverty	21.2	19.0	45.6	34.7

Elderly living alone are twice as likely to be poor as those who live with others and an astonishing 65 percent of black females living alone are poor. Persons 85 and older are nearly twice as likely to be poor as those aged 65-74 and 71 percent of the very old are women.

What Programs Exist to Address These Needs?

Despite Federal programs designed to address the economic and

nutritional needs of the elderly, serious gaps exist in the so-called "social safety net."

By far, the most successful anti-poverty program for the elderly is Social Security. Improved adequacy and regular indexation of benefits instituted during the 1970s are almost single-handedly responsible for the dramatic reduction in poverty among the aged. Just 25 years ago, more than one-third of the elderly population was poor. Fifteen years ago, poverty was twice as high among the elderly as for other age groups.

Today, poverty among the elderly is comparable to that of the general population. But lower income elders are enormously dependent upon Social Security. Aged households with incomes under $5,000 receive 80 percent of their income from Social Security. Such households receive only 11 percent of their income from public assistance programs. Social Security income prevents 9.4 million older persons from falling into poverty and reduces the poverty rate for the aged from 47.6 percent to 12.4 percent.

Those older persons who do not escape poverty through Social Security payments may be aided by the Supplemental Security Income (SSI) program. But in most cases, SSI does not prevent poverty, as Federal payments are set at 75 percent of the poverty line for individuals, 90 percent for couples. Furthermore, only about one-third of the elderly poor receive SSI.

The maximum Federal SSI benefit is just $336 a month for an individual, $504 for a couple. While many states supplement the Federal payment, almost none bring recipients over the poverty line. Even when maximum SSI benefits are added to food stamp benefits, only four states bring aged individuals out of poverty. Nationally, the Federal SSI benefit for individuals combined with Social Security and food stamps amounts to just 84 percent of the poverty line.

Disturbing as these figures are, they may present an overly optimistic picture, for, in addition to low participation in SSI, fewer than one-third of poor families containing an elderly member receive food stamp benefits. Participation levels are even lower for aged individuals living alone. Only 15 percent of elderly families in poverty receive Social Security, SSI and food stamps.

Low participation by the elderly in the SSI and food stamp programs has been noted often, but little has been done to address

this problem. Studies to date have found lack of information to be the predominant reason for non-participation.

Several other factors contribute to income inadequacy among the elderly which can lead to poor nutrition. According to the Labor Department's Consumer Expenditure Survey, older persons spend a higher proportion of their income on food, housing and health care than any other age group. Federal programs designed to address these needs also have gaps in coverage.

The Low-Income Home Energy Assistance (LIHEAP) and Weatherization programs give priority assistance to the elderly poor. Unfortunately, funding levels are too low to serve more than one-third of those eligible. Persons receiving heating assistance get, on average, just $208 for an entire winter. To date, as many as 13 million eligible housing units remain unweatherized. Residents of those homes continue to face unnecessarily high fuel bills.

While most elderly persons are covered by Medicare, only one-third of the elderly poor also receive Medicaid. This means that most of the elderly poor must pay Medicare co-payments and deductibles and pay out-of-pocket for uncovered services such as eyeglasses and prescription drugs. Even those covered by both Medicare and Medicaid often have substantial gaps in coverage.

The two programs specifically designed to meet the nutritional needs of the elderly are Congregate and Home-Delivered Meals. The creators of these programs recognized the diversity of reasons why older persons may lack adequate nutrition and, therefore, mandated that senior meals programs be available to all older persons, regardless of income. However, Congress wisely acknowledged the special needs of the poor and required that services be targeted to persons with the "greatest social and economic need."

Unfortunately, funding levels for these programs have always been woefully inadequate. In 1984, more than seven million persons 60 years and older lived below 125 percent of the poverty line. Yet only two million seniors of "greatest economic need" were served by either Congregate or Home-Delivered Meals Programs in FY 1985. In other words, fewer than one-third of the highest-risk/highest-priority group of elders is being served. Even those who are served generally receive just one meal a day, five days a week.

Despite the Congressional mandate to target services to the poor, the ability of service providers to accomplish this goal has

diminished over the past five years. Whereas, in 1982, 61 percent of congregate meal participants were economically needy, that proportion had dropped to 53 percent in 1985, after having fallen to 56 percent in 1983 and 1984.

There has been considerable concern among service providers that the drop in low-income participation is linked to strenuous efforts by the Administration to collect more "voluntary contributions" from program participants. The Older Americans Act allows service providers to solicit voluntary contributions for meals but no one may be turned away for failure to contribute.

The purpose of such contributions is to expand the number of meals served, but the Administration has advocated the use of voluntary contributions to replace Federal responsibility. In its FY 1987 budget document, the Department of Health and Human Services stated that contributions have increased from $69.1 million in 1981 to a projected $156.9 million in 1987.

If this increase is related to declining participation by the poor, its utility may be questionable. It is important that meal programs reach the highest-risk seniors. If requests for contributions are overzealous, the pride of those too poor to pay may be assaulted and they will be driven away from this important program. It appears that this is already happening.

There is another area in which the Administration has weakened its commitment to helping the aged poor receive nutritional assistance. When the regulations to the Older Americans Act were overhauled last year, the requirement that all service providers assist participants in taking advantage of benefits available to them under the Food Stamp Program was deleted. Under the new regulations, only home-delivered meal providers would be required to provide any assistance and the specific reference to food stamps was eliminated.

Although more than half the participants in senior meals programs are poor, only 13 percent of congregate meals participants and 19 percent of home-delivered meals participants receive food stamps.

Not only is participation in the Food Stamp Program low for elderly persons, but benefit levels for recipients are meager. Average food stamp benefits are just $45 a person per month and this amount is usually even lower for elderly beneficiaries.

Considering the large number of older persons with low incomes

and the inadequacy of coverage of nutritional assistance and income maintenance programs, it is not surprising that hunger among the elderly is problematic.

A considerable body of evidence has been compiled which reveals that increasing numbers of older persons are resorting to emergency food centers in an attempt to meet their nutritional needs. Not only do many find it demeaning to turn to such services, but soup kitchens and food pantries are not always able to provide nutritionally balanced meals. This is a particular problem for older persons who often have medical conditions which require special diets.

Recommendations

There clearly needs to be more public education directed to the low-income elderly informing them of Federal programs for which they may be eligible. An important first step was taken during reauthorization of the Food Stamp Program last year, when Congress directed Social Security offices to provide beneficiaries with information about food stamps and to assist SSI participants in applying for benefits.

Such efforts should be expanded. Social Security offices are familiar to and utilized by virtually all older persons. As such, they should expand efforts to notify persons with small Social Security benefits of the availability of SSI and food stamp benefits. They should also be far more active in assisting such persons in applying for benefits.

The other currently existing structure with which many older persons are comfortable and familiar is that of the Older Americans Act programs. These programs were designed to provide comprehensive assistance to older persons. Congregate and home-delivered meal providers are in an ideal position to make available information about the Food Stamp Program.

Unfortunately, funding reductions and freezes in these programs make it difficult for service providers to expand their range of activities. This is especially true as the size of the aging population continues to grow. The National Council of Senior Citizens strongly recommends that new funding be allocated specifically to help OAA service providers inform and assist participants with food stamp information.

We also believe additional funds are needed to expand meal

services to currently unserved low-income elderly persons. In our view, it is not cost-effective to cut corners on nutrition programs which can help preserve the health of our nation's older citizens.

Finally, the nutritional needs of the elderly would be addressed by raising Federal SSI benefits at least to the poverty line. It is very difficult to ensure nutritional adequacy for persons whose incomes are insufficient.

If we are to make a serious attempt to end hunger among our nation's elders, it is essential that program benefits and funding for services be made adequate. In addition, eligible persons must be informed of the existence of these programs and assisted in participating.

Prepared Statement of Adelaide Carpenter, Volunteer, Elderly Feeding Pilot Project, Polk County, Iowa

Chairman Panetta, Chairman Roybal, members of the Committee:

Thank you for allowing me this opportunity to share with you some of my personal experiences while serving as a volunteer with the Elderly Feeding Pilot Project as these experiences relate to hunger and aging in Polk County, Iowa.

I am Adelaide C. Carpenter and I was born in Guttenburg, a small town in Northeastern Iowa. I graduated from Iowa State Teacher's College in Cedar Falls, Iowa, and taught school for ten years before my marriage. I lived most of my married life in Coon Rapids, Iowa. I worked as a legal secretary and bookkeeper in my husband's law and insurance office for almost twenty-five years. For two years following his death I continued the insurance business. I have since sold this business and now spend my time doing volunteer work.

With my three children grown and out of the home, I took a VISTA assignment in 1966 and served in a Day Treatment Center for the emotionally disturbed at Coney Island Hospital, Brooklyn, New York.

My interest in volunteer work continued over the next eleven years and I served in the following projects:

1. 1974 - 1979. Served as a neighborhood visitor for Grace United Methodist Church in Des Moines, Iowa.

2. 1979 - 1980. Worked as a VISTA Volunteer with the Legal Services Corporation of Iowa, Senior Citizen's Project, Des Moines, Iowa.

3. 1980 - 1986. I volunteered at these Des Moines, RSVP projects: The Botanical Center, Shepherd Center for Senior Citizens, Secretary of State's Uniform Commercial Code office, as a Small Claims Mediator at the Polk County Court House, and at the Elderly Feeding Project.

I became involved in the Elderly Feeding Project because I heard Velma Flisher, Director of the Elderly Feeding Project, speak about the Project at a Legislative Advocacy Group of which I am a member. I decided it would be a challenging way for me to become involved in a worthwhile project. I have found the hands on experience to be very satisfying and gratifying and have been with the Project since its beginning in 1982.

I believe the Elderly Feeding Pilot Project is the most useful and rewarding of any of the government programs I have worked with, both to the clients as well as the volunteers involved. This is due in large measure to the able administration of Project Director Velma Flisher and Director of Volunteers, Mary Ann Juhl, both of the Des Moines office.

Since its beginning in 1982, I have delivered commodities to low income homebound elderly and made client certifications and recertification visits for the program. Each of these jobs has involved personal communication in the client's home, sitting at a table with them, looking into their eyes and sometimes seeing the pain of those having to accept "welfare." Indeed, many could not keep tears from their eyes as they described hardships they had overcome without government help.

I know that some of the participants are getting food stamps, others received mobile meals, often trying to save portions of food so they'd have something that night or on the weekends. Some of those that were not homebound (who were accepted after the second year of the project) also participated in the Congregate Meal Program which provides a noon meal. Many of the elderly I served, even though eligible for these programs, wanted no part of these other programs. I would now like to tell you of some of my experiences while delivering commodities to the elderly so that you might have a better picture of what this program meant to the low income elderly.

One of my first trips delivering commodities was to a little cottage with peeling paint on an unsurfaced street with no curb and gutter. It was my first stop of the day with 46 lbs. of commodities. After knocking hard and waiting several minutes, Bessie, age 86, opened the door with one hand, while hanging on to her walker. She was so happy to see me and smiled as I told her I'd be bringing her food in. After getting the two large boxes into her kitchen I sat down at the table with her to answer her questions first.

"How do you use those dry packaged eggs? I'm not sure about farina, how do you use it? . . .

She asked if I would put the things in her cupboards, and I felt like Old Mother Hubbard when I opened the doors: they were nearly bare. While stashing things away I listened to her problems and fears. Her $289.00 Social Security check wasn't allowing for anything other than the bare necessities, and without energy assistance and help from the Board of Supervisors on her real estate taxes, along with the commodities, she couldn't make it.

Another visit took me to a second floor apartment above an empty business. Hannah, partially blind, called for me to come up when I pushed her buzzer in a cluttered and filthy hallway. I carried the commodities into a small apartment that had little furniture but much stuff and junk was piled on what little furniture there was. The commodities had to be kept on the floor as the kitchen was only a former clothes closet. But Hannah was pleased as I helped her feel the different packages and told her what was in them. She could tell by size and feel the difference in the dry milk, potatoes and eggs. Can you imagine what the commodities meant to her?

On yet another delivery to a "homebound:" The 93 year old lady who answered my knock one cold, snowy and windy morning greeted me,

"I was afraid you'd not make it on a day like this."

I just said the wind had helped me along and that I had her two boxes of goodies. After they were all on her kitchen table she was anxious to look them over.

"Do you know what I'm going to eat tonight? That farina I really like for breakfast and if there are raisins I'll put a hand full in too. I want to cook my own meals 'cause I know what I like best. These dried eggs! I never thought I'd use that stuff. But I've learned they aren't so bad if you doctor them up a bit. But I do miss seeing and hearing the hens."

I listened to her as I got all the commodities I could on the shelves and she looked up and said, "Don't close the doors, please, I want to see everything."

Bertha's total monthly income was $312.00.

On a certification visit I met Lizzie. Lizzie knew for some time that others in her building were receiving commodities because they had suggested she apply too. Lizzie was much too proud to apply and it wasn't until she got down to empty cupboards that she had a change of mind.

So Lizzie, who is 87, walked 2 miles through the streets of Des Moines to the Project office to apply for the commodities. No one was able to see her that day, but I was sent out the following day to interview her. She wanted to know details and "not do anything wrong . . ." Her 63 year old son, who was not able to move around, listened quietly. As I described the available commodities, Lizzie interjected,

"Oh, fruit juice - we haven't had any for months . . . peanut butter! It's been too expensive. . ."

And her son's eyes would brighten when he told me,

"Mom's a good cook if she just has something to cook with."

Their combined monthly income was below the level for one so they qualified but because the program's quota was filled at that point they had to be put on the waiting list. Lizzie cried as I left because she never thought she'd have to beg for food. She went out with me to the car thanking me again and again and wiped the tears away before I waved goodbye.

During a recertification I visited a couple, one 86 and one 84, living in a very tiny house on the edge of the city. They cried when I got there and wiped tears away when I left. Why? Because they felt ashamed because they were asking for food. Social Security was their only income and their medications were costing more than usual. They showed me the nearly empty freezer and refrigerator, the cupboards and their medical bills and talked of a garden they hoped they could have. They did qualify and were certified for four years. Without commodities they would not be able to adequately feed themselves.

CONCLUSION

As you can tell, I am really enthusiastic about this program. I know from first hand experience what a great need it is filling, a need that food stamps, mobile meals, and congregate meals cannot meet.

I know that if any of you could accompany me on my rounds delivering these food packages and talking to those being helped and seeing their expressions of joy and relief when I give them their food, you would have no problem with voting to keep this program alive and kicking.

Des Moines, Detroit, and New Orleans have demonstrated the value of the program, and that the volunteer system does work. Now it is up to Congress.

I know that you will not disappoint me and my many friends back in Iowa; friends that I have made serving in this program; friends that just need a helping hand.

Prepared Statement of Dr. David A. Lipschitz, Director, Geriatric Research Education and Clinical Center, John L. McClellan Memorial Veterans Hospital and Professor of Medicine, Director, Division on Aging, University of Arkansas for Medical Sciences

Hunger can manifest in various ways. Generally we think of the suffering emotional and otherwise, which occurs when economically deprived individuals present with symptoms related to an inadequate access to food. The physician community in the United States is likely to see hunger present primarily in the elderly population manifesting with hunger's most serious medical complication, namely malnutrition. Malnutrition may present in a number of ways. The most classically described disorder which we will expand on later is protein calorie malnutrition. This disease occurs in individuals who have taken in too few calories and too little protein for a prolonged period of time. More rarely other symptoms result from inadequate food intake. Of most importance is deficiencies of vitamin A and zinc, which occur in elderly subjects who have consumed inadequate amounts of food. These individuals lose their ability to taste food, lose their appetite and lose their ability to fight infections. It is not surprising that these individuals who are now anorectic and frail are likely to continue a relentless progression of a problem which manifests with the serious complications of malnutrition; namely confusion, dehydration and serious, often fatal bacterial infection.

There is some evidence that nutritional reserve capacity is compromised with aging. Thus subtle inadequacies of food intake caused by a change in social circumstance, or the presence of a coexisting disease may well result in a serious nutritional problem in an older individual.

The Prevalence of Protein Calorie Malnutrition.

Epidemiologic studies have shown that nutritional deficiencies are rare in affluent healthy elderly Americans. In elderly from low socioeconomic groups, however, nutritional deficiencies of some severity are much more common. The highest prevalence of protein calorie malnutrition is in hospitalized elderly patients. Most evidence suggests that at least 65% of elderly individuals admitted to hospital have a serious nutritional problem. It is our experience in the Geriatric Evaluation Unit at the John L. McClellan Memorial Veterans Hospital, that as many as half our elderly subjects have severe-protein calorie malnutrition which warrants some form of nutritional intervention program.

The Clinical Features of Protein-Calorie Malnutrition in the Elderly

In the vast majority of cases protein-calorie malnutrition in the elderly, like in other age groups, is associated with the presence of a primary disease which is the main cause for hospitalization for that individual. Diseases

associated with malnutrition include cancer, chronic heart and lung disease, renal or hepatic failure and chronic infections such as tuberculosis. These diseases by themselves are associated with decreased appetite which results in inadequate intake of food. In an older individual this anorexia can rapidly lead to symptomatic malnutrition. Of most importance to this subcommittee is the fact that we also frequently see elderly individuals who present to hospital with starvation as their primary diagnosis. These subjects are usually indigent, have extremely poor social circumstance and have very low incomes. A recent change in environment, such as institutionalization is not uncommon. These subjects will not or cannot cook for themselves; they are frequently depressed and may have had a recent medical illness which has compromised their ability to function independently in the community. These subjects have grossly inadequate food intake and eventually present to hospital with the complications of protein-calorie malnutrition.

Patients rarely come to hospital saying, Doctor, I am starving. Rather they come with the complications of protein-calorie malnutrition. These include weight loss, dehydration, and infection. Invariably these patients are confused and they may be delirious. Not uncommonly they are found semiconscious in their homes by a relative or a friend and are disoriented for time and place. An unfortunate fact is that the admitting physician will frequently not recognise that malnutrition is the major underlying cause for the patient's clinical presentation. The dehydration and infection will be recognized and treated and the confusion will be ascribed to senile dementia. Once the infection and dehydration have been corrected the patient will frequently be discharged back to his or her own environment only to be readmitted a short time later with a worsening problem that may prove fatal.

How do we Diagnosis Protein Calorie Malnutrition?

There are simple laboratory tests which provide strong clues that a nutritional problem is present in an individual patient. For example, the serum albumin (a test that is invariably obtained on admission to hospital), is markedly reduced in subjects with protein-calorie malnutrition. Furthermore other laboratory parameters that are routinely obtained can provide supportive evidence to indicate a serious nutritional deficiency.

How is Protein Calorie Malnutrition Treated?

Malnourished elderly patients who present to hospital are usually extremely ill. The initial focus of management should be to correct their life threatening medical disorders. It is possible to correct dehydration and treat infections even in older malnourished persons. The futher management of

their nutritional problems should be based on clinical judgment and the presence or absence of coexisting disease that may indicate the patient's chance for long term survival. For example, if the patient has an incurable disease, such as a cancer which is anticipated to result in imminent death, aggressive nutritional intervention may not be appropriate. The majority of elderly malnourished patients, however, have reversible disease and obvious rehabilitation potential. These patients require an intensive rehabilitation program that not only corrects their nutritional deficiencies but also pays attention to their social circumstance, environment, ability to function independently and their family interactions. This comprehensive approach is required to assure that the problem resulting in hospitalization does not recur.

Nutritional deficiencies require weeks to months to correct. Because malnourished older individuals lose their appetite it is frequently not possible for them to consume sufficient food voluntarily. These subjects may require a special form of feeding that utilizes a flexible small bore polyethylene tube, that is passed through the nose and stomach into the patient's duodenum. Nasogastric feeding, also referred to as enteral hyperalimentation, allows the correction of nutritional deficiencies. In an enclosed report we present clinical evidence that this approach can result in the correction of protein calorie malnutrition in the elderly.[1,2] It can result in improvement in mental function, weight gain and increase the ability of these individuals to fight infection. Correction of nutritional deficiency and appropriate rehabilitation can improve the quality of life of these patients and prevent nursing home replacement. We have many examples of older individuals who have received six weeks of rehabilitation at our Veterans Administration Hospital who have gone back to the community and have led productive lives for many years.

The Special Challenges for the Future.

Major changes are occurring in the way in which we practice medicine. Providing six to eight weeks of rehabilitation for nutritional deficiencies in an acute care hospital is no longer an option under new DRG (disease related group) re-imbursement guidelines. The Veterans Administration has provided, I believe, a leadership role for the nation in intermediate and long-term rehabilitation for the geriatric patient. These programs have clearly been shown to be cost effective by minimizing the need for institutionalization and preventing recurrent admissions to hospital. This model of geriatric rehabilitation has unfortunately not been extensively developed in the general medical community. It is clear, therefore, that the creation of a greater

opportunity for geriatric rehabilitation is a critical need. At the current time there are few health care providers who recognize the potential of rehabilitating elderly individuals with nutritional and other medical problems. This can be achieved by appropriate hospitalization in a long-term care rehabilitation facility. I am enclosing a copy of the results of a model program of geriatric rehabilitation that was developed and pioneered by the Little Rock Geriatric Research Education and Clinical Center (GRECC) which is now becoming a standard for care of elderly veterans throughout the Veterans Administration Hospital system.[3] There are minimal if any opportunities available for those non-veteran elderly citizens who are frail and require support services. There is a need to develop intermediate care hospital beds where elderly subjects with nutritional and other problems can be cared for in a cost effective manner. These sites should be available for elderly individuals who have utilized their maximum acute care medicine stay under current law but are still not well enough to return to their homes. This concept of short-term-long-term care is one that cannot be over emphasized.

There is also a critical need for a greater emphasis on nutrition in the education of physicians and all other health care professionals. This has to be the responsibility of medical schools and other colleges that train nurses, social workers, etc.

An additional major need is to assure that compromised older individuals who are likely to have nutritional problems have easy access to community support services. As I am sure you have heard, or will hear, there are certain issues with regard to community support that require urgent attention. It is apparent to me that there are large numbers of neglected elder citizens in communities across America who are either unaware or who are for various reasons unable to become eligible for urgently required nutritional and other support services.

Finally, I must add that I believe that the solution to the medical predictament of hunger in elderly individuals involves a restructuring of our current medical priorities. By paying attention to the health and welfare of older individuals and by assuring their continued productivity we will minimize the opportunities for creating nutritional deficiencies and hopefully by a process of disease prevention and health promotion minimize the need for expensive medical resources. A preventative approach to disease will also hopefully substantially improve the quality of life of older Americans and allow them to remain independent in the community for as long as possible.

References

1. Lipschitz, D.A. and Mitchell, C.O.: The Correctability of the Nutritional, Immune and Hematopoietic Manifestations of the Protein Calorie Malnutrition in the Elderly. Journal of Parenteral and Enteral Nutrition, 6:226, 1982.

2. Lipschitz, D.A.: Protein Calorie Malnutrition in the Hospitalized Elderly Patient. Primary Care, 9:531, 1982.

3. Liem, P.H., Chernoff, R. and Carter, W.J.: Geriatric Rehabilitation Unit: A 3-year Outcome Evaluation. Journal of Gerontology, 41:44, 1986.

Prepared Statement of Velma Flisher, Program Manager, Supplemental Food Programs, Polk County, Iowa

Chairman Panetta, Chairman Roybal, members of the Committee:

Thank you for allowing me to submit this written testimony concerning the Elderly Feeding Pilot Project as it exists in Polk County, Iowa. I am Velma Flisher, Program Manager, Supplemental Food Programs, Polk County, Iowa.

The Elderly Feeding Pilot Project was established by Congress (Public Law 97-98) as an outgrowth of the Commodity Supplemental Food Program (CSFP). It began September, 1982. The purpose of the program was to test distribution of commodity food supplements as a cost effective way to relieve chronic undernutrition among the poor elderly. By every estimate, at least 25% of our nation's elderly are poor and without adequate food to sustain their health and well being.

The three Pilot Projects were located in Detroit, Michigan, New Orleans, Louisiana, and Des Moines, Iowa. All three cities were already involved in the distribution of supplemental food to women, infants and children through the Commodity Supplemental Food Program (CSFP).

When the program began in 1982 we were authorized to serve 1,600 low income, homebound persons 60 or older. In January, 1984, we were allowed to start serving low income elderly in addition to the homebound elderly. At the present time we are serving 4,102 persons per month of which 50% are homebound. We serve a yearly total of 49,224 food packages. Our food package cost as of January, 1986 was $12.97 per package.

In January, 1984, we took a standard food package (see Attachment #2) and did some comparison shopping at a discount grocery store, a chain type grocery store, and a neighborhood store. The cost of the food package at the discount store was $49.21, at the chain store $53.87, and at the neighborhood store $63.96 (see Attachment #1).

In July of 1983, we moved to offices located at 314 S.W. 9th on the north side of the Keck Warehouse Building. This helped to improve the efficiency of our program operation as our food is stored in this warehouse. Both the CSFP and the EFPP are located here.

Nutrition education and information is handled through Iowa State University Extension Service. It is provided at the local distribution site on a one-to-one basis, in the homes, and in group sessions at the 15 congregate meal sites in Polk County. This part of the program has made the elderly being served accutely aware of the value of good nutrition and how they can use the commodities to achieve good nutrition.

Staff for the Elderly Pilot Project consist of:

1 - Social Worker Aide
1 - Storekeeper
1 - Volunteer Coordinator
1 - Part time Warehouseman
1 - One-half time Program Manager

In the case of the homebound clients, the food packages are either picked up by proxies or delivered by approximately 250 volunteers. These volunteers contribute on an average of 1,500 volunteer hours per month or what would be the equivalent of ten full time employees.

We have a linkage with State, County and local agencies, providing services to the low income elderly, in our geographical area of Polk County, thus creating a referral system of services available to our clients.

The EFPP's strengths are the quality and quantity of food available and the use of volunteers to deliver food, to work in the warehouse, to provide support services, and to work with the participants, which results in a substantial savings of dollars through lowered administrative cost. The Volunteer System has helped make the program very cost effective. It has benefited participants tremendously in terms of new friends, assistance with their problems, and just having someone to talk to. It has given the participant a new resource in their life and has put new meaning and purpose into the life of the volunteers.

The food package contains foods from the four major food groups (see Attachment #2). Being able to buy high quality, nutritious food is one of the problems that any elderly person living on a low monthly fixed income has to face. This food provided through EFPP has been invaluable to the participants in terms of providing them their only source of good nutritious, wholesome food.

Other benefits to the client are:

1. The food package tailoring to meet specific nutritional and medical needs of individual participants (i.e., diabetic, low salt, right to refuse foods not meeting dietary needs, etc.).

2. Referral system to other agencies to assist participants with special and other needs.

3. Provide service to homebound clients specifically by delivering food packages to their homes. In addition to delivering the food packages, the volunteers are trained to spot and to deal with other problems that may be confronting the typical homebound participant.

4. Nutrition education required to be provided as part of the program.

I would now like to address some of the problems with the EFPP.

Funding poses a problem. We need to know in advance what our yearly allocation is, in order to plan our budget accordingly.

Restricting EFPP's to only areas where a CSFP exists presents another problem area. For future programming purposes I would certainly hope that EFPP's could be started in communities across our nation without having to be affiliated with a Commodity Supplemental Food Program, since there are only 27 CSFP programs in operation at this time. To do otherwise would seem to me to discriminate against low income elderly citizens living in areas not having a Commodity Supplemental Program for women, infants, and children.

According to 1980 census figures, Polk County has approximately 11,000 low income elderly. We have been authorized to serve 4,102 persons per month, of which 56% are homebound (see Attachment #3). This means there are approximately 7,000 potential clients that are not being served. It is true Polk County has other feeding programs for the elderly, i.e., food stamps, mobile meals, congregate meals, and even the food bank. But none of these programs ensure proper nutrition and good health for our seniors. The above mentioned programs leave a gap in the three meal a day concept as well as no assistance whatever on holidays and weekends. It is important to eat three meals a day. The commodity program does allow these persons to have three meals a day. It allows those participants who are living on a small fixed income to live with a small amount of dignity. It is important for the elderly to remain in their own homes and out of health care facilities. Good nutrition is instrumental in allowing this to happen. The average income of a low income household is between $450.00 and $500.00 per month - with the high medical cost and the high utility bills, there is no doubt these people need help to assist in making ends meet.

There are still thousands of elderly poor waiting to be served. We are not attempting to recruit any new applicants for the program. We have approximately 500 applicants on a waiting list. We add from the waiting list whenever we have a participant drop from the program for whatever reason. It is tragic that we have to tell the poor elderly - we will put you on a waiting list, but it may take eight to ten months before you hear from us.

CONCLUSION

The distribution of surplus commodities to provide wholesome and nutritious food to the low income elderly has proven its worth. It is my observation from first hand experience that the EFPP has enhanced the quality of life of the 4,100 persons being served in Polk County and at the same time has enhanced the quality of life for those volunteers working in the program.

I would encourage Congress to stick to their guns and keep this program alive and funded. I would ask you what other government program serves the basic food needs of the low income elderly at such a small cost per person.

ATTACHMENT #1

ELDERLY FEEDING PILOT PROJECT

PACKAGES SERVED: 4,100

	*VALUE OF PACKAGE	COST FOR TOTAL PACKAGES	SAVINGS THRU USDA
U.S.D.A	$12.97	$ 53,177.00	- 0 -
DISCOUNT STORE	$49.21	$201,761.00	$148,584.00
CHAIN STORE	$53.87	$220,867.00	$167,690.00
NEIGHBORHOOD STORE	$63.86	$261,826.00	$208,649.00

* Community Store Prices are based on an average of packages for a women, an infant and a child.

Cost of U.S.D.A. Package was obtained from Nancy Palmer, U.S.D.A. Regional Office, Denver, Colorado, on January 3, 1986.

ATTACHMENT #2

STANDARD PACKAGE

A Standard Package (one month supply) consists of the following:

Evaporated Milk	3 - 12 oz. Cans
Instant Non-Fat Dry Milk	1 - 4 lb. Box
Farina Cereal	2 - 14 oz. Pkgs.
Egg Mix	2 - 6 oz. Pkgs.
Peanut Butter	1 - 1 lb. Can)
- or -	) every other month
Dry Beans	1 - 1 lb. Pkg.)
Canned Beef, Pork, Turkey, Chicken	1 - 29 oz. Can
- or -	
Meat Ball Stew	2 - #303 Cans
Vegetables and/or Fruit	4 - #303 Cans
Dehydrated Potatoes and/or While Milled Rice	1 - 1 lb. Pkg.
Juice	3 - 46 oz. Cans
Cheese	1 - 5 lb. Loaf
Butter	1 - 1 lb. Brick
Honey	1 - 3 lb. Jar - Quarterly
Raisins	2 - 1 lb. Boxes

If a client is on a doctor's prescribed diet, the food package is tailored to the extent possible. No participant has to accept any item they cannot use or do not want.

ATTACHMENT #3

POLK COUNTY
DEPARTMENT OF SOCIAL SERVICES
ELDERLY FEEDING PILOT PROJECT
PARTICIPANT PROFILE
QUARTER ENDING DECEMBER 31, 1985

CLIENT COUNT - 4,069

	TOTAL	
HOMEBOUND		
Yes	2,205	54%
No	1,858	46%
GENDER		
Male	1,078	26%
Female	2,943	72%
AGE		
60-62	591	15%
63-65	563	14%
66-68	537	13%
69-71	539	13%
72-74	518	13%
75+	1,265	31%
No Response	9	
PUBLIC ASSISTANCE SUBSIDIES		
Food Stamps	1,144	28%
Rental Assistance	814	20%
Medicaid	600	15%
Homemaker Services	310	8%
Home Health Services	219	5%
Other	3,222	79%
No Response	138	
HOUSEHOLD COMPOSITION		
Live Alone	2,253	55%
With Spouse	1,282	32%
With Children	309	8%
With Other Relative	139	3%
With Non-Relative	78	2%
No Response	20	
PRESENT HEALTH PROBLEMS		
Diabetes	614	15%
High Blood Pressure	1,917	47%
Arthritis	2,448	60%
Heart Disease	1,167	29%
None	441	11%
Other	1,451	36%

	TOTAL	
INCOME SOURCES		
SSA	3,116	77%
SSI	206	5%
SSA & SSI	378	9%
VA	346	9%
Civil Service	38	1%
Pensions	521	13%
Employment	111	3%
Other	411	10%
Unknown	9	
None	168	4%
No Response	2	
MONTHLY GROSS INCOME		
0-200	386	9%
201-250	228	6%
251-300	375	9%
301-400	1,180	29%
401-500	1,002	25%
501-600	588	14%
601-700	219	5%
701+	101	2%
No Response	3	
REFERRAL SOURCE		
Friend/Relative	1,981	49%
Clergy	33	1%
Media	542	13%
Medical Facility	25	1%
Physician	139	3%
Social Service Agency	935	23%
Other	469	12%
No Response	11	
INITIAL CONTACT		
Home Visit	1,672	41%
Site Visit	2,383	59%
ETHNIC GROUP		
White	3,514	86%
Black	487	12%
Hispanic	7	
Indian	3	
Oriental	29)	1%
Asian	29)	

88

82

Prepared Statement of William R. Moyer, Past President, National Association of Nutrition and Aging Services Programs, Seattle, WA

Mr. Chairman and distinguished members of the House Select Committees on Hunger and Aging.

I am William Moyer, a Nutrition Project Director from Seattle/King County and Immediate Past President of the National Association of Nutrition and Aging Services Programs. I thank you on behalf of NANASP for your invitation to testify before this joint committee on the subject of Hunger and the Elderly.

The numbers of elderly and hungry are increasing. Hunger in America, which had been virtually eliminated in the seventies through services provided by the Food Stamp Program, Women, Infants and Children Program (WIC), School Lunch Program, The Nutrition Program for the Elderly and the USDA Surplus Commodity Program has been drastically reversed in the eighties. This tragic reversal is the direct result of Public Social Policy which has seen the Federal Government begin to dismantle effective programs to combat hunger and to reduce appropriations for such programs.

Ronald Reagan and Congress slashed anti-hunger expenditures between 1981 and 1984, by more than $12 billion. Estimates of those going hungry each month in America are now at 20 million citizens and the numbers are growing. The Harvard-based Physicians Task Force on Hunger declared hunger to be "a national health epidemic". The U.S. Conference of Mayors described hunger to be "probably the most prevalent and the most insidious problem" facing American cities. Senator Edward Kennedy, following his field investigation on the problem of hunger in five different American cities, concluded that "for the first time since the 1960's, and perhaps since the Great Depression, hunger is on the rise in America".

Study after study has reached the same inescapable conclusion. We as a nation are losing the battle against hunger. Indeed, we may even be retreating from it. Congress must no longer criticize the current administration for its repressive policies and then pass its bills into law!

During the past five years despite a decline in real (or constant) federal dollars, in terms of Older Americans Act appropriations for

61-275 O - 86 - 4

NUTRITION SERVICES, THE ACTUAL NUMBER OF MEALS PROVIDED HAS INCREASED TWENTY PERCENT, FROM 188 MILLION MEALS IN 1981 TO 225 MILLION MEALS IN 1985. SEVERAL FACTORS ACCOUNT FOR THIS INCREASE. COMPETITIVE BIDDING BY NUTRITION PROJECTS FOR MEALS AND EQUIPMENT, CONSORTIUM BUYING OF SUPPLIES WHENEVER POSSIBLE, PURCHASING FOODS FROM NATIONAL COMMODITY PROCESSING CONTRACTORS, MAXIMUM UTILIZATION OF BONUS DAIRY COMMODITIES, INCREASING THE NUMBER OF SERVICE DAYS AT NUTRITION SITES, STAFF REDUCTIONS WHEREVER POSSIBLE AND OTHER MANAGEMENT DECISIONS. HOWEVER, THE GREATEST SINGLE FACTOR ACCOUNTING FOR THE INCREASE IN MEALS IS RELATED TO THE INCREASE IN PARTICIPANT DONATIONS. PARTICIPANT DONATIONS INCREASED FROM $71 MILLION IN 1981 TO $121 MILLION IN 1985. SURELY, THIS IS NOT THE "PRIVATE SECTOR INITIATIVE" THAT THE ADMINISTRATION BOASTS WILL FUND NEEDED HUMAN SERVICE PROGRAMS ACROSS THE COUNTRY.

IN ADDRESSING THE PROBLEM OF HUNGER AMONG THE ELDERLY, THE CONTINUED ROLE OF THE USDA CASH/COMMODITY PROGRAM IS ESSENTIAL. AT PRESENT, MOST NUTRITION PROJECTS HAVE ELECTED TO RECEIVE CASH IN LIEU OF COMMODITIES, A CHOICE MADE YEARS AGO AND NOT UNRELATED TO THE ITEMS MADE AVAILABLE TO NUTRITION PROJECTS BY USDA WHICH WERE NOT APPROPRIATE FOR THE ELDERLY. HOWEVER, DURING THE PAST YEAR THE NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS HAS WORKED DIRECTLY WITH USDA OFFICIALS TO MAXIMIZE THE COMMODITY UTILIZATION IN OUR PROJECTS BY INCREASING THE UNDERSTANDING OF USDA PROGRAMS BY OUR NUTRITION PROJECTS AND VICE VERSA.

CONGRESS COULD DO MUCH TO HELP OUR NUTRITION PROGRAMS BETTER ALLEVIATE HUNGER. THREE THINGS STAND OUT. FIRST, CONTINUE THE NATIONAL COMMODITY PROCESSING CONTRACTS. THESE ALLOW PRODUCT MANUFACTURERS TO UTILIZE SURPLUS COMMODITIES IN THEIR PRODUCTS AND TO REDUCE THE PRODUCT PRICE TO NUTRITION PROJECTS BY THE VALUE OF THE COMMODITIES USED. THERE IS A CONSIDERABLE LACK OF REAGAN ADMINISTRATION SUPPORT TO CONTINUE THIS PROGRAM.

SECOND, REMOVE THE REQUIREMENT THAT ONLY THOSE STATES THAT HAVE ELECTED TO RECEIVE AT LEAST 51% COMMODITIES VERSUS CASH ARE ELIGIBLE TO RECEIVE NON-DAIRY BONUS COMMODITIES SUCH AS GROUND BEEF AND POULTRY. THIS IS PARTICULARLY IMPORTANT SINCE A MAJOR SURPLUS OF BEEF IS ANTICIPATED THIS YEAR AND, AT PRESENT, OUR PROJECTS CANNOT RECEIVE AND UTILIZE THIS PRODUCT.

FINALLY, AND THIS RELATES TO THE TWO PREVIOUS POINTS, CONGRESS MUST INSURE THAT AS MUCH FLEXIBILITY AS POSSIBLE EXISTS FOR NUTRITION PROJECTS TO BENEFIT FROM SURPLUS COMMODITY FOODS. TO HAVE FOOD ROTTING IN WAREHOUSES WHILE AMERICAN CITIZENS GO HUNGRY IS SENSELESS, WASTEFUL AND CRUEL. ALL OF THESE CAN BE ACCOMPLISHED THROUGH POLICY CHANGES WITHOUT THE NEED FOR ADDITIONAL APPROPRIATIONS.

ALTHOUGH MUCH CAN BE ACCOMPLISHED THROUGH WISE POLICY CHANGES, THERE IS NO QUESTION THAT IF THE PROBLEM OF HUNGER IS TO BE SERIOUSLY ADDRESSED, ADDITIONAL FUNDS ARE NECESSARY. IF THE INDISCRIMINATE MEAT-AX APPROACH TO A BALANCED BUDGET UNDER GRAMM-RUDMAN IS ALLOWED TO FALL, NUTRITION PROGRAMS AND OTHER PROGRAMS THAT FIGHT HUNGER WILL BE DEVASTATED AND HUNGER WILL BE CATAPULTED TO A NATIONAL CRISES.

CONGREGATE AND HOME DELIVERED NUTRITION PROGRAMS FOR THE ELDERLY ARE A PROVEN SUCCESS AND HAVE DEMONSTRATED THIS SINCE 1973. THESE PROGRAMS SIGNIFICANTLY IMPROVE THE NUTRITIONAL WELL BEING OF THOSE WHO PARTICIPATE, THE PROGRAMS ARE WELL MANAGED AND THE PROGRAMS ARE VERY WELL ACCEPTED BY THE ELDERLY. WE DO NOT NEED BETTER PROGRAMS, BUT RATHER WE NEED BETTER FINANCIAL SUPPORT FOR THE PROGRAMS WE HAVE.

AT PRESENT OVER HALF OF THE SUPPORT FOR THESE PROGRAMS COMES FROM NON-FEDERAL AUSPICES. THIS INCLUDES, IN ADDITION TO PARTICIPANT DONATIONS: IN-KIND COMMUNITY SUPPORT IN THE FORM OF FACILITIES; UTILITIES; EQUIPMENT; AND VOLUNTEER SUPPORT, MUCH OF WHICH IS FROM THE ELDERLY THEMSELVES. THE NATIONAL NUTRITION PROGRAM FOR THE ELDERLY STANDS AS AN EXCELLENT EXAMPLE OF A PUBLIC-PRIVATE PARTNERSHIP IN HUMAN SERVICE DELIVERY. THE PARTNERSHIP NEEDS TO BE STRENGTHENED THROUGH A RENEWED FEDERAL COMMITMENT THAT ONLY CONGRESS CAN PROVIDE.

BROWN, LARRY J., CHAIRMAN, PHYSICIAN TASK FORCE ON HUNGER IN AMERICA, HUNGER IN AMERICA THE GROWING EPIDEMIC, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH, BOSTON, MASSACHUSETTS, 1985.

KENNEDY, EDWARD M., SENATOR, REPORT TO THE COMMITTEE ON LABOR AND HUMAN RESOURCES, UNITED STATES SENATE, GOING HUNGRY IN AMERICA, WASHINGTON, D.C., DECEMBER 22, 1983.

MARGOLIS, RICHARD J., "HOW HUNGER STAGED A COMEBACK", FOUNDATION NEWS, VOLUME 29, NUMBER 6, NOVEMBER/DECEMBER 1985, PP. 29-29.

U.S. HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON HUMAN SERVICES OF THE SELECT COMMITTEE ON AGING, OLDER AMERICANS ACT: A STAFF SUMMARY, WASHINGTON, D.C., U.S. GOVERNMENT PRINTING OFFICE, 1985.

PREPARED STATEMENT OF ROSALIE S. ABRAMS, STATE SENATOR, DIRECTOR, MARYLAND STATE OFFICE ON AGING

My name is Rosalie S. Abrams and I am the Director of the Maryland Office on Aging. I am pleased to be here to testify before this Select Committee which is looking into one of the most critical issues facing us today - the very real need to provide decent, adequate nutrition for our growing population of senior citizens and to prevent serious health problems that result from undernutrition.

1. Undernutrition may account for a substantially greater portion of illness among elderly Americans than has been assumed according to several medical experts on aging. Medical concern about undernutrition among the aged is rising as the numbers of elderly climb and as surveys reveal how poorly millions of them eat.

Many gerontologists have been both alarmed and excited by evidence that undernourishment may cause much of the physiological decline in disease resistance seen in elderly patients, a weakening of immunological defenses that has commonly been blamed on the aging process. The immunologic studies also hold out the promise that many individuals can lighten the disease burden of old age by eating better. Geriatric undernutrition is most common and most severe among the ill, the improverished and the isolated. But inadequate nutrition which can result from the loss of taste, the side effects of drugs or from depression as well as from disease and poverty, has been found to be surprisingly prevalent among the affluent as well. Scientists now estimate that anywhere from 15 percent to 50 percent of Americans over the age of 65 consume insufficient levels of calories, calcium, iron, the B complex vitamins and vitamin C. Since diet is implicated in 6 of the 10 leading killer diseases and since nutrition plays a role in the treatment of 4 of the most prevalent chronic conditions of the elderly--cardiovascular diseases, cancer, hypertension, and diabetes mellitus--the importance of the nutrition programs for the elderly cannot be overstated.

The older population is at major risk of chronic disease problems. The elderly are the heaviest users of health services. In 1983, the elderly composed 12% of

the population. More than 4 out of 5 persons 65 and over have at least one chronic condition, and multiple conditions are commonplace among the elderly with women having higher rates of long term chronic disease. With a greater prevalence of chronic conditions, older persons use medical services and facilities more frequently than younger persons. They are hospitalized approximately twice as often as the younger population, stay twice as long, use twice as many prescription drugs, and account for one third of the country's total personal health care expenditures. By 1970, the government was spending on Medicare what it had projected it would spend by 1990. From $3 billion a year, these programs grew 20% a year to where they may top 100 billion in 1987. In 1984 Medicare was responsible for 49% of all personal health care expenditures and costs for hospitals account for 69% of all Medicare dollars. While the overall poverty rates for persons age 65 and over have differed in recent years - the figure for 1984 was 12.4%. Poverty rates for the 85 and older age group was nearly twice that of the 65 to 74 age group. In 1984 nearly one in three women 85 years of age and older was poor or within 125% of poverty.

It is this group-those 85 and over who have the highest health care costs, and are the most severely disabled and ones at greatest risk.

A congressional briefing on the Cost Effectiveness of Nutrition Support in January of this year included a new study conducted by Arthur Anderson and Company. (international public accountants) supported by a medical research grant from the Ross Laboratories, a division of Abbott Laboratorie, which reported the economic effect of malnutrition on direct variable costs on the hospitalized. The report found that:

- Fifty-five percent of the patients studied were likely to be malnourished, but fewer than 5% received nutrition support prior to developing complications or early in their hospitalization: poorly nourished patients had 3 times the number of major complications, and they were 3 times more likely to die.
- Even without a complication, malnourished patients

cost hospitals more per patient than well-nourished patients. However, if a complication occurred, the charges for hospitalization more than doubled in the case of malnourished patients. These increased charges were $5,000 and $10,000 for medical and surgical patients, respectively.

- Malnourished patients with pneumonia, fractured hip, or inflammatory bowel disease stayed 2 days longer, cost the hospital $1,160 more per patient, and had charges that were $2,480 per patient more than well-nourished patients.
- The economic effect was even greater for surgical patients with hip surgery, bowel surgery, or abdominal vascular surgery, where malnourished patients stayed 5 days longer, cost the hospital $2,750 more per patient, and had charges of $5,575 more per patient.

A new study of the nutrition program for the elderly confirms the value of the program in reducing undernutrition among older participants and in preventing many elderly from becoming isolated in their own communities.

Dr. Mary Bess Kohrs of the University of Illinois at Chicago reports in her studies of the meal programs that the programs provided more than 70 percent of the Recommended Dietary Allowance (RDA) for protein and Vitamins A and C for men and women. "Regular participants in congregate and home delivered meals programs had improved blood levels of Vitamins A and C and none were Vitamin A deficient after three years in the program. However, in the non-participant control group, 40 percent had low vitamin levels."

Another major impact of the congregate meal program is to keep the elderly in touch with other people, Kohrs reports, noting that socialization is important for many who live alone and are isolated from their families. Kohrs said that for some participants, including retired lawyers, judges and teachers the program gave them a chance to stay in touch with their peers. For others, the program served in a different way. Dr. Kohn states that "for the elderly person who lives alone and is on a limited

budget, getting a well-balanced diet is a problem. Those living in poor areas may not have food stores in their neighborhood or they might be afraid to go out alone because of crime."

National Institute on Aging statistics show that one-third of congregate meal program participants and two-thirds of home delivered meal recipients were age 75 or older. Over half had low incomes, with 52 percent earning below $6,000 a year.

"Those benefitting the most from the meal programs are persons over age 75, older women and persons fromthe lowest socio-economic group," Kohrs reports. Her studies concluded that the nutrition programs should focus on reaching persons 65 years of age or older and who have low incomes. Kohrs said that more outreach is needed to contact these target groups, and she emphasized that nutrition education is needed among all older persons in the community.

2. Providing nutrition to the aging individual is a preventative, cost- effective approach to problems facing the elderly.

In my present position as advocate for the more than 600,000 senior citizens in Maryland and in my 18 years of legislative experience in the General Assembly, I have witnessed a phenomenal growth in the number of elderly in my home state, especially those 85 years of age and over, many of whom are frail and for whom a continuum of community based services are needed. I think members of this Committee are familiar with this extraordinary population growth. Maryland's demographic data illustrates a tremendous growth in population age 65 and over, but an even greater increase among our senior citizens 85 and over.(Chart I)

The subject of today's hearing - Hunger Among the Elderly cannot be looked upon as something in isolation. As the recently published and distinguished Harvard Study on Medicare states," in the long run the most effective way to reduce inappropriate health care utilization is to provide a wide array of alternative social services such as homemakers, meal services, respite and day care." Nutritional needs are a critical

part of a larger issue affecting the most vulnerable of our senior citizens, - primarily the frail elderly, 85 and over, living alone and in isolation without adequate family or other forms of social support. An adequate program of nutrition is needed to fill a very important link in the continuum of care for these individuals.

We in Maryland have been working very hard to broaden community based services which include nutrition services, to meet this need. One program is called Gateway II designed to insure interagency coordination of community-based long term care services to disabled older persons, and to provide additional "gap-filling" services for those eligible because of low income so that a person at risk of nursing home placement receives all the services needed to remain in the community. The Gateway II program has demonstrated its cost effectiveness and certainly allows the individual to remain in his or her own home. The average community- based care for a Gateway II client costs the public $254 per month. If the same client (who is Medicaid eligible) enters a nursing home, his institutional care would cost the public $834 per month.

Home delivered meals are a vital part of the in-home services and cost $6 per day for delivery of two meals which meet 70% of the older clients' nutritional needs.

Nutritional needs of the elderly are partially being met, not only through the Gateway II system, but through the broad program of congregate and home delivered meals provided through our 18 area agencies. I believe that Maryland has one of the more effective nutrition programs. Through the limited Older Americans Act funds we receive (level funding in spite of increasing numbers and increased costs), in FY 1985 we served 2,500,000 meals to more than 45,304 participants, as well as 1,300,000 home delivered meals to 3,600 participants. We received $5,795,389 in Older Americans Act funds. Last year in Maryland, we received almost $1,200,000 in contributions which was used to maintain existing nutritional services.

Operating costs of the Eating Together programs in

Maryland were offset by the use of 5,600 volunteers (90% of whom were aged 60+). In addition to voluntary contributions from participants, local support comes from local governments, fund raisers, private industry, (profit and non-profit), and fraternal and professional organizations amounts to approximately $900,000 statewide.

Incidentally, the Older Americans Act was the only major Federally Funded nutrition program not sheltered by Gramm-Rudman. We are facing as much as a 15% reduction in federal funds in 1987. This will result in a decrease of 500,000 meals. Currently there are 274 nutrition sites in Maryland. Level federal funding limits 74 sites at 3 or fewer days per week service. Furthermore, home-delivered meals served from these sites are served only when the site is open. Thus the homebound individual receives meals only 1 to 3 times per week. The expected cut in funds will further affect our programs. Senior centers will be forced to limit days of operation and in some instances to close entirely.

The need for meals also includes the need for transportation to the places where the meals are offered, or transportation for home-delivery of meals. Federal funds formerly available to support rural and urban mass transportation systems have been severely reduced in recent years, and increasingly, it is now incumbent upon the State governments and local communities to support transportation programs for senior citizens.

A distinguished Task Force on Nutrition and Hunger appointed by Governor Hughes submitted a recent report which highlighted as one of its findings, the severe hunger problems among the elderly in Maryland, and recommended an additional $1.6 million dollars annually to deal with this problem. This would allow a 5% increase in participation in the home-delivered and congregate program; meals to over a 6.2% population increase and an additional 5% increase in Elderly Nutrition Service in FY 1987. We have made a start to address this need--a supplemental appropriation of $400,000 was requested by the Governor and approved by

the General Assembly. This special appropriation will target State General Funds through local Area Agencies on Aging to provide nutrition, both in the form of congregate meals and home delivered meals, but it will not offset projected cuts in funds as a result of Gramm-Rudman in Fiscal Year 1987.

Even with these additional State resources, with cash contributions from seniors themselves and local support, the nutritional needs of our elderly citizens are not being met. The level funding which has been a hallmark of Older Americans Act appropriations in recent years has failed to provide for the growing population to be served and the rise in food and other costs of the nutrition program.

In summary, one of the most essential needs of the elderly are programs which assure the maintenance of good health. An essential part of good health care is a continuum of services including that of nutrition, particularly home delivered meals which are needed for the frail elderly. Efforts at the local and state level as I have described have tried to meet this need even in the face of scarce resources, yet one of the major aims of the Older Americans Act in my opinion has been thwarted by the failure on the part of the Federal government to meet its commitment.

Finally, I emphasize that it is important to consider nutritional services as part of a continuum of care of services in the community to those at the greatest risk of institutionalization and any new or expanded programs that deal with nutritional services have to be incorporated under the umbrella of the continuum of care.

I appreciate very much the opportunity to offer this testimony today and I am ready to answer any questions that you may have.

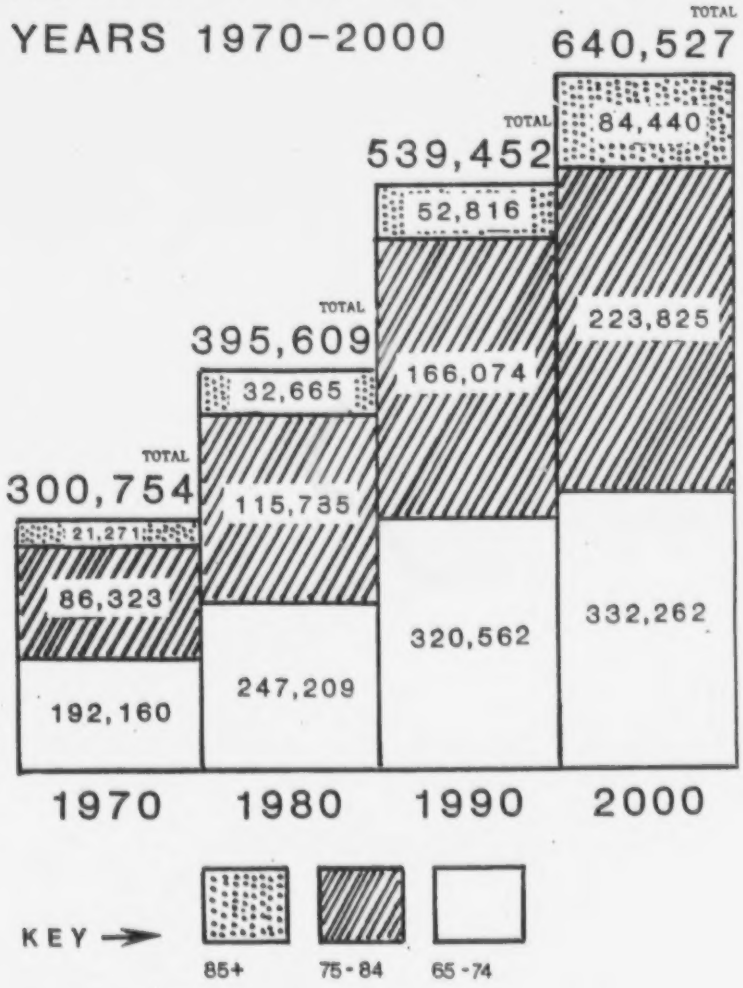
Thank you.

Chart I

ELDERLY POPULATION IN MARYLAND

AGES 65 & ABOVE .

YEARS 1970-2000



STATE OF MARYLAND

FINAL RECOMMENDATION
GOVERNOR'S TASK FORCE ON FOOD AND NUTRITION

The Elderly

Four hundred thousand individuals in the State are aged 65 or older. By 1990 the figures is expected to increase by 25%. The number of poor is estimated at 11%. Forty six thousand individuals participate in the congregate meal program. Over 31,000 individuals are however, believed to be non institutionalized homebound elderly frail who cannot go to a congregate meal site. Currently there are less than 3,000 homebound who are recipients of any nutrition support services. This is a gaping programatic deficiency. This problem will cotninue to grow. It will touch every community within the State. New and creative approaches must be implemented to meet the nutritonal needs of this invisible population.

Achieve the maximum use of Federal elderly nutrition dollars by taking the following actions:

1. increase the number of elderly poor participating in organized nutrition programs

2. improve coordination of existing transportation service for the elderly as well as services with the new statewide special transportation assistance program.

3. identify the current unmet need and maintain age related statistics to better target services to the elderly

The State should take additional steps to meet the needs of the elderly by taking the following actions:

1. Assure 5 day/week meal service in home delivered meals in all parts of the State.

2. Provide State support for a 5% increase in Elderly Nutrition Services in FY 87 and each year thereafter.

In the Interim Report the Task Force recommended a 5% increase in the number of elderly poor participating in organized nutrition programs, and a 5% increase in the number of home delivered meals to the frail, disabled and homebound be supported by State funds. This would permit the programs to reach more eligible participants, keep sites open 5 days per week, provide meals where needed on weekends, and provide special meals for those whose medical conditions require modifications.

Because of inadequate federal funds plus 5% inflation and increased meal cost a reduction in the meals served in 1986 is expected to be approximately 6%. The population increase will be approximately 6.2%.

The Office on Aging request for State funds for year 1987 is

Summarized below:

5% increase per Task Force recommendation	$ 408,068
6.2% additional meals for population increase	506,009
Increase meals to 1984 level	718,249
	$1,632,326

*Includes $163,518 home delivered meals.

3. **Develop alternate systems for home delivered meals.**

The Maryland Office on Aging and the Department of Health and Mental Hygiene should together consider the feasibility of a plan to use the WIC home-delivery purchasing and distribution system to serve the frail elderly homebound. In addition other creative approaches to delivering meals to the frail homebound elderly poor should be explored.

By 1990 the 400,000 Marylanders age 65 and older will have grown to 500,000. As the elderly become more frail, the number of home-delivered meals needs to be increased, yet limited funding has thus far prevented services from expanding to meet the growing need. Basic problems will need to be resolved in "piggy-backing" home-delivered meals to the elderly onto the WIC program, including differences in food needs of the two populations and the collection of payment for the senior meals. However, similar programs are already in operation in three other states. The potential integration of the two programs should influence decisions made regarding retention of the WIC home delivery project.

Integrated Food and Nutrition Plan for State

Under the authority and with the guidance of the Governor's Council create an annual State Food & Nutrition Plan by establishing a joint cross-agency food and nutrition needs-assessment and planning process among the four agencies administering food programs in the State. This process should take advantage of a Federal Executive Order on Plan Reform, which provides for the "simplification, consolidation, and substitution" of federally required State plans, on the State's initiative.

Inadequate coordination among the State agencies, combined with the absence of any governing State policy on food and nutrition matters contributes significantly to gaps in service and to our difficulties in mustering resources to meet new &/or growing needs. A policy capable of ordering program priorities and driving the allocation of resources is a significant step in the State's commitment to assure adequate food and nutrition to all Marylanders.

A coordinated plan will afford the opportunity for the State to use the program planning process as a vehicle to highlight Maryland's food and nutrition agenda in ways such as:

1. developing and implementing gubernatorial and legislative initiatives which cut across agencies and programs;

2. identifying client needs and setting priorities among competing needs;

3. improving the management of State agency programs, building interagency consensus by jointly developing program plans & strategies;

4. improving the linkage between policy-making and budget decisions;

Prepared Statement of Michio Suzuki, Associate Commissioner, State and Tribal Programs, Administration on Aging

MR. CHAIRMAN AND MEMBERS OF THE HOUSE COMMITTEES ON AGING AND HUNGER, I AM PLEASED TO BE HERE TODAY TO DISCUSS THE ADMINISTRATION ON AGING'S NUTRITION PROGRAM AS PART OF YOUR HEARING ON HUNGER AND THE ELDERLY.

SINCE IT WAS INSTITUTED IN 1972, THE NUTRITION PROGRAM FOR THE ELDERLY HAS BEEN A FAVORITE OLDER AMERICANS ACT PROGRAM AMONG OLDER PEOPLE, AND ONE IN WHICH THEY ACTIVELY PARTICIPATE AS CONSUMERS, AS WORKERS, AS VOLUNTEERS, AND AS ADVISORS. THE PROGRAM HAS GROWN SO THAT, IN FY1985, 2.9 MILLION OLDER PERSONS WERE SERVED IN THE CONGREGATE NUTRITION PROGRAM, AND 693,000 ELDERLY PERSONS IN THE HOME-DELIVERED MEALS PROGRAM. THIS IS IN KEEPING WITH THE FUNDAMENTAL PHILOSOPHY OF THE OLDER AMERICANS ACT: OLDER PEOPLE WHO PARTICIPATE IN ITS PROGRAMS SHOULD TAKE AN ACTIVE ROLE IN THE OPERATION AND OVERSIGHT OF PROGRAMS WHICH SERVE THEM.

I AM CONVINCED THAT THE NUTRITION PROGRAM IS MEETING A NUMBER OF IMPORTANT SOCIAL, NUTRITION AND HEALTH RELATED NEEDS. IN PARTICULAR, THERE ARE OLDER PERSONS AT THE BOTTOM OF THE SOCIAL AND ECONOMIC LADDERS OF SOCIETY WHO CAN BENEFIT SUBSTANTIALLY FROM OLDER AMERICANS ACT PROGRAMS. IT IS TO THEM THAT OUR PROGRAMS MUST ALWAYS REACH OUT. THIS MANDATE IS AND HAS BEEN EMPHASIZED IN OUR COMMITMENT TO TARGET RESOURCES TO THOSE OLDER PERSONS IN THE GREATEST SOCIAL AND ECONOMIC NEED AND TO THOSE VULNERABLE ELDERLY MOST IN DANGER OF LOSING THEIR INDEPENDENCE.

THE OLDER AMERICANS ACT REQUIRES THAT WE ASSURE THAT PREFERENCE BE GIVEN TO PROVIDING SERVICES TO OLDER INDIVIDUALS WITH THE GREATEST ECONOMIC OR SOCIAL NEEDS. HOWEVER, WE ARE ALSO REQUIRED TO AVOID USE OF A MEANS TEST FOR ELIGIBILITY FOR SERVICES. THROUGH OUTREACH AND LOCATING THE SERVICES IN NEIGHBORHOODS WHERE NEEDY PEOPLE LIVE AND THROUGH OUR COMMITMENT TO TARGET SERVICES TO THOSE VULNERABLE OLDER PERSONS MOST IN DANGER OF LOSING THEIR INDEPENDENCE, THE PROGRAM HAS COME TO SERVE PRIMARILY THE PEOPLE THAT CONGRESS INTENDED.

OUR PRELIMINARY NATIONAL DATA FOR FISCAL YEAR 1985 INDICATE

THAT 56% OF THE PEOPLE SERVED IN THE CONGREGATE NUTRITION PROGRAM ARE LOW INCOME; 17% ARE MINORITY. THE HOME-DELIVERED MEALS COMPONENT OF THE NUTRITION PROGRAM IS EVEN MORE ORIENTED TOWARD THE NEEDY, WITH 63% OF THE HOME-DELIVERED MEALS DELIVERED GOING TO LOW-INCOME PERSONS AND 19% OF THE HOME-DELIVERED MEALS TO MINORITIES.

SITE LOCATION IS ONE MEANS OFTEN USED TO TARGET NUTRITION PROGRAMS TO AREAS OF GREATEST NEED. THOUGH AOA ENCOURAGES ESTABLISHING SITES IN REMOTE RURAL PLACES AND LOW INCOME URBAN NEIGHBORHOODS, THE DETERMINATION OF THE ACTUAL LOCATION OF CONGREGATE MEAL SITES IS LEFT FOR STATE AND AREA AGENCIES ON AGING TO DETERMINE. THESE DECISIONS ARE DIFFICULT, BUT WE BELIEVE THAT STATE AND AREA AGENCIES HAVE APPROPRIATELY CARRIED OUT THESE RESPONSIBILITIES. ANALYSIS OF NATIONAL SURVEY DATA IN 1983 SHOWED THAT ALMOST ALL STATES WEIGHTED THEIR INTRA-STATE FUNDING FORMULAS IN TITLE III ALLOCATIONS TOWARD ONE OR MORE SPECIAL TARGET GROUPS:

- ABOUT 90% HAD WEIGHTS BASED ON THE NUMBERS OF ELDERLY POOR
- MORE THAN 50% WEIGHTED THE FORMULA TOWARDS MINORITY AGED: AND
- OVER ONE THIRD HAD SPECIFIC WEIGHTS TO TARGET FUNDS TOWARD THE RURAL ELDERLY.

IT SHOULD BE POINTED OUT THAT MORE NUTRITION SERVICES ARE BEING TARGETED TO HOME BOUND ELDERLY EACH YEAR ANALYSIS OF THE TITLE III EXPENDITURE DATA SHOWS THAT MOST STATES ARE TRANSFERRING FUNDS OUT OF THEIR TITLE III-C1 ALLOTMENTS FOR CONGREGATE MEALS, AND INTO THEIR III-C2 ALLOTMENTS FOR HOME DELIVERED MEALS. IN FY 1985, TITLE III-C2 EXPENDITURES INCREASED 3.7% BECAUSE OF TRANSFERS. THIS MEANS THAT MORE DOLLARS ARE BEING SPENT EACH YEAR FOR THIS HOMEBOUND GROUP, WHO ARE NOT ONLY DISABLED, BUT ALSO MORE LIKELY TO BE OLDER AND SOCIALLY ISOLATED. THIS IS A GROUP WHICH IS ALWAYS VULNERABLE TO HUNGER AND MALNUTRITION.

WE HAVE DONE A GREAT DEAL TO IMPROVE THE NUTRITION PROGRAM FOR OLDER PEOPLE. THE ADMINISTRATION ON AGING'S PROGRAM AND

FINANCIAL INITIATIVES INCLUDE A NUMBER OF ROAD MAPS TO ASSIST THE AGING NETWORK IN ITS EFFORTS TO IMPROVE THE CONGREGATE AND HOME DELIVERED MEALS PROGRAMS.

- O THE PROGRAM INCOME INITIATIVE, FOR EXAMPLE, HAS INCREASED CONTRIBUTIONS STEADILY SINCE THE INITIATIVE BEGAN: FISCAL YEAR 1981, $69 MILLION; FISCAL YEAR 1982, $90.7 MILLION; 1983, $102.7; AND FISCAL YEAR 1984, $113.7 MILLION; AND FISCAL YEAR 1985, $121 MILLION. THIS MONEY IS USED TO PROVIDE MORE MEALS AND THUS HELPS US TO SERVE MORE OLDER PEOPLE OR TO PROVIDE ADDITIONAL MEALS TO THOSE WHO NEED THEM.

- O OUR PERFORMANCE-BASED CONTRACTING INITIATIVE IS BEING CONSIDERED AND IMPLEMENTED BY MANY NETWORK PROVIDERS AS A MEANS TO "GET MORE FOR SCARCE DOLLARS" AND TO SERVE MORE OF THE "AT RISK" POPULATION.

- O THE NUTRITION PRODUCTIVITY INITIATIVE IS EXAMINING THE RETURN ON FEDERAL INVESTMENT IN THE MEALS PROGRAM. WE ARE LOOKING AT SUCH APPROACHES AS: EFFECTIVE USE OF VOLUNTEERS IN LOWERING LABOR COSTS; IMPROVED FOOD SERVICE MANAGEMENT; PARTNERSHIPS WITH THE PRIVATE SECTOR; AND USE OF UNTAPPED RESOURCES TO AUGMENT FEDERAL FUNDS AND INCREASE THE NUMBER OF MEALS SERVED AND PEOPLE REACHED

ALL OF THESE INITIATIVES HAVE BEEN SUCCESSFUL THROUGH THE COOPERATION, THE COMMITMENT, AND THE DEDICATION OF THE ENTIRE AGING NETWORK.

I THINK THAT IT IS IMPORTANT TO MAKE A DISTINCTION BETWEEN NUTRITION SERVICES FOCUSED ON PROVIDING MEALS RELATED TO PROMOTING HEALTH AMONG OLDER PARTICIPANTS AND IN FEEDING HUNGRY PEOPLE WHERE THE FOOD SERVED MAY OR MAY NOT RELATE TO HEALTH NEEDS. ONE OF THE IMPORTANT GOALS OF THENUTRITION SERVICES PROVIDED UNDER THE OLDER AMERICANS ACT IS TO SERVE BALANCED MEALS WHICH ARE RELATED TO HEALTH NEEDS.

THE FOOD SERVICE DELIVERY SYSTEM ANALYSIS, AN AOA SUPPORTED STUDY BY KIRSCHNER ASSOCIATES AND COLORADO STATE UNIVERSITY IN

1981, INDICATED THAT, IN GENERAL, THE MEALS SERVED DO MEET THE NUTRITIONAL GOAL OF SUPPLYING AT LEAST 1/3 OF THE RECOMMENDED DIETARY ALLOWANCES, AND THEY DO RELATE TO HEALTH AS REQUIRED BY THE OLDER AMERICANS ACT. HOWEVER, THE STUDY DID INDICATE THAT THERE ARE SOME IMPORTANT NUTRITIONAL CONCERNS WHICH MUST BE ADDRESSED SO THAT THE NUTRITION PROGRAM CAN MAKE A MAXIMUM CONTRIBUTION TO THE HEALTH OF PARTICIPANTS. SERVICE PROVIDERS MUST CONSIDER NOT ONLY WHAT NUTRIENTS ARE BEING SUPPLIED, BUT ALSO HOW THOSE NUTRIENTS ARE PRESERVED AND RETAINED FOR OPTIMUM HEALTH BENEFITS.

AoA HAS PROVIDED ALL STATES AND AREA AGENCIES ON AGING WITH INFORMATION WHICH REEMPHASIZES THE NECESSITY FOR BASING THE NUTRITIONAL QUALITY OF MEALS SERVED ON RECOMMENDED DIETARY ALLOWANCES (RDA). WE ARE EMPHASIZING THE IMPORTANCE OF NUTRITIONAL QUALITY, NUTRITION EDUCATION, AND HEALTH PROMOTION. THE ABILITY TO STRENGTHEN THE CAPACITY OF THE NUTRITION PROGRAM IN BOTH QUALITY AND QUANTITY OF MEALS SERVED IS FIRMLY ROOTED IN THE COMMITMENT OF ALL PERSONS ENGAGED IN THE AGING NETWORK, AND MEMBERS OF THE VOLUNTARY AND PRIVATE SECTORS. THAT COMMITMENT, PRESENT IN ALL THESE GROUPS, WILL HELP US BETTER SERVE THOSE OLDER PERSONS WHO NEED AND WHO RELY ON OUR SERVICES.

MR. CHAIRMAN THIS CONCLUDES MY PREPARED REMARKS. THIS ADMINISTRATION IS DEEPLY COMMITTED TO IMPROVING THE QUALITY OF LIFE FOR ALL THIS NATION"S OLDER CITIZENS. WE APPRECIATE THIS OPPORTUNITY TO SHARE INFORMATION ABOUT SOME OF OUR EFFORTS.

1836-1986

Texas Department On Aging

P.O. BOX 12786, CAPITOL STATION, AUSTIN, TEXAS 78711, PHONE 512/444-2727 (S/TDD)

O.P. (BOB) BOBBITT, Executive Director

BOB GIBBONS, Board Chairman

April 9, 1986

The Honorable Mickey Leland
Room 419 Cannon House Office Bldg.
Washington, D.C. 20515

Dear Congressman Leland:

We are writing concerning USDA reimbursement for meals provided under the Older Americans Act. The Department of Agriculture Commodity/Cash-in-Lieu Program was authorized and sufficient funds were appropriated by Congress during FY85 to reimburse states for meals served to the elderly at the rate of 58.75 cents. In February 1986, USDA announced that the rate would be 53.618 cents for FY85.

In Texas, the decreased rate has resulted in a loss of $692,152. Service providers have managed to complete FY85 without decreasing the number of meals served in congregate or home delivered meal programs through increased economies and funds from other sources. However, we expect the impact of the FY85 decrease to be felt this year in a loss of approximately 300,000 meals. The size of the cuts in federal funding this year, including the planning figure of 52.92 cents from USDA for FY86, has already resulted in decreases in the first six months in the number of meals served at nutrition sites in Texas.

You need also to be aware that a reduction in meals served now results in decreased USDA reimbursements in the future. The loss from this ripple effect constitutes an additional $176,000 or approximately 73,000 meals. These cuts will have severe consequences. We see no chance of state and local governments in Texas making up those cuts. All this is occurring at a time when the need is greater than ever and growing.

We also want to alert you to proposals made by USDA to transfer the Commodity/Cash-in-Lieu Program from U.S.D.A. to the Department of Health and Human Services. The State of Texas opposes on principle the transfer of programs between agencies when they are operating adequately. The cost involved in such a transfer will have no benefit to the public or state governments.

We have an additional reason in Texas for wanting to keep the Commodity/Cash-in-Lieu Program within USDA. We are currently working with the Texas Department of Human Services on a more efficient and economical system for distribution of U.S.D.A. commodity foods that would enable our Department to take part of its entitlement in commodity foods rather than all in cash. We view this effort as having benefits for programs for the elderly, as well as for the farm economy and the federal agriculture budget. Other states are likely to follow the lead set in Texas. We want to deal with a single agency for reimbursement under this entitlement, and that agency should continue to be USDA, since it will presumably continue to manage commodity food distribution.

Finally, related to the role of USDA in our programs, if USDA would provide the same technical assistance to nutrition programs for the elderly as it does to the public schools to develop efficient systems for use of commodity foods, the states would be able to accept a significant amount of entitlement in commodity food. We have, through a discretionary grant to improve purchasing practices, had access to excellent assistance from USDA. We had no idea and other states had no knowledge that such expertise existed in Washington. Making that expertise more widely available would enable states to work with USDA to plan the most economical food assistance programs.

In summary, we want to work with federal agencies to save funds and are prepared to suggest ways that would allow states to continue to provide food assistance to as many as possible of those in need. Please contact me if you have any questions about these issues.

Sincerely,

O. P. Bobbitt

O. P. (Bob) Bobbitt
Executive Director

OPB/JB/ng

TESTIMONY ON HUNGER AND THE ELDERLY IN TEXAS

The Texas Department on Aging is the state's principal advocate for the elderly. The problem of hunger, especially for the homebound elderly, is a major concern. This year marks the first year in which state funds have been appropriated for nutrition services in the form of the Omnibus Hunger Act and allocates to the Texas Department on Aging $2.5 million for home-delivered meals for the 85-86 biennium. This testimony begins with presentation of data, trends and conditions and is followed by comments from a home-delivered meal provider in Harris County which reflect those of service providers across the state.

The data in Table I shows the number of people served in 1985 and projections based on those funding cuts which we are told to expect, in both the state budget and in the federal budget if Gramm-Rudman goes into effect for FY 1987. The Texas Department on Aging does not collect data on many of the meals provided and some of the data are gross estimates. Table II is an attempt to describe unmet needs. The data is drawn largely from surveys done in 1984 and 1985.

The impetus for the Omnibus legislation was the 1984 report **Faces of Hunger in the Shadow of Plenty** by the Texas Senate Interim Committee on Hunger and Nutrition. Part of the evidence cited in that report was taken from a 1984 key informant survey reported in **Hunger and Nutrition Research Project** by the Texas Department on Aging. A 1985 survey conducted by Dr. Karen Harlow at the Southwest Texas Long-Term Care (SWLTC) Gerontology Center in Dallas statistically validated the earlier report. The results of the Texas Special Census by the Texas Department of Human Services will soon be released at which time the Department on Aging will determine the most effective approach for a follow-up key-informant survey this year.

The currently available data highlights the following major conditions and trends:

1. There are currently 2.12 million Texans 60 years and older. There will be 3.48 million by the year 2000. The elderly population in Texas is growing dramatically. Those 60 and over will increase 21%, and those 75 years and over will increase 55% during the second five years of this decade.
2. There are over 100,000 elderly who do not have enough to eat,

according to a statistically valid telephone survey conducted by the SWLTC Gerontology Center.

3. We estimate 16,000 homebound elderly need and would qualify for home-delivered meals. Of the estimated 16,000 total, an estimated 4,000 are on waiting lists. It is impossible to estimate how many of the remaining 12,000 could be reached through outreach by existing programs and served, if funds were available.

4. We estimate 100,000 mobile elderly have problems with food access that would be alleviated by participation in some type of food assistance program. Lack of money is the primary factor. It is impossible to estimate how many would attend a congregate meals program.

5. According to the Texas Department of Human Services, those Texans aged 65 and over with incomes at or below 125% of poverty number 23% of the total population. There is an inordinately high proportion of Black women over 75 years among Texas' poor. People 60 and older participating in the food stamp program number 5.7% of the total population.

5. We estimate conservatively that 10% of all elderly who are in need of nutrition services have a very critical need for those services on weekends and holidays and do not receive them; 5% have a very critical need for two meals per day. There are increasing numbers of service providers serving morning snacks or breakfast at nutrition sites in response to this need.

6. One-third of Texas elderly need special diets, according to the survey by SWLTC Gerontology Center. Over one-fifth have heart disease. Almost 70% have one or more chronic diseases. Very few nutrition providers have the resources or knowledge to plan and provide meals that meet the United States Dietary Guidelines.

7. Almost 5% of Texas elderly do not have transportation to the grocery store, according to the survey by SWLTC Gerontology Center. Over 40% have one or more physical impairments. In a key informant survey done this year, transportation was rated as the highest priority among services for the elderly. Long-term care services, such as in-home services, was rated second. Home-delivered meals was rated third. As great a need as there is for

nutrition services, the need for these supportive services is perceived as even greater by those working in the field.

Information was requested this week from Ms. Antoinette Samuel, Director, Harris County Area Agency on Aging. It was reported that recent funding cuts have resulted in caps on meals resulting in a daily average of 140 mobile elderly being denied services at nutrition sites and 275 homebound elderly being denied requests for meals as reported to the area agency.

Ms. Thelma Pierre, Director, Houston Metropolitan Ministries nutrition services, providing 1,200 home-delivered meals in Houston, reported that the waiting list of eligible homebound elderly is growing daily and is around 320. She explained that other service providers in Houston probably have long lists. Ms. Pierre believes that the waiting list figures are the tip of the iceberg. She explained that many additional calls and applications are received by people who do not qualify for the program because they are not homebound, but they do not have money to buy food. The food pantries in Houston have continuous problems keeping inventories.

As is typical throughout Texas, Ms. Pierre believes that there are <u>at least</u> as many elderly in the community who are eligible for nutrition services and do not apply as there are currently receiving services. One major reason is social isolation. They do not know who to call. Outreach is an essential part of reaching all of those in greatest need. Another factor that is very prevalent in the age group over 75 years, particularly in Texas, is pride. There is a cultural preference to maintain a self-image of self-reliance and dignity. Asking for help, particularly from government agencies, is a very last resort that a large number of Texas elderly find impossible to do. Another phenomenon that has been observed in West Texas has been the alienation of people to government programs when they experience funding cuts. In one community where many elderly were decertified from SSI and no longer eligible to receive the meals they had been receiving, the local community rallied and replaced the federally-funded meals. By the time meals were available again, some had died and others were so suspicious that they chose not to become involved.

Up until six months ago, Houston Metropolitan Ministries never had to refuse a referral from a hospital discharge planner.

The number of referrals have increased and there are currently no slots available. Eligible referrals are placed on a waiting list that is prioritized through individual needs assessment. Occasionally workers finally have a slot available and find that the applicant has died. Ms. Pierre has found a need for in-service counselling with her employees to help them overcome the depression and the thought that the failure of their agency to provide a meal might have made a difference.

In just the past week, a new trend has emerged for the agency in response to the downward spiral of the local economy. Because 80% of the agency's clients rely solely on the one meal provided with government funds, the agency developed a supplemental program called the "Weekend Connection" using volunteers to take home-prepared meals to elderly clients. Supplemental food packs were also being purchased privately for distribution to the agency's clients. Because so many of the volunteers were in middle-management positions and have lost their jobs, they can no longer afford to volunteer. These resources appear to be drying up.

Reports from agencies throughout Texas indicate a worsening of the economic and health condition of clients. Elderly are being released from hospitals in very weak conditions and are reported to be entering nursing homes in much weaker conditions than before implementation of the Medicaid prospective payment system and diagnosis-related groups. It is the definite impression of those working in the field that the weak condition of elderly with health problems combined with inadequate nutrition is resulting in vastly more subsequent preventable medical problems and hospitalizations. It is very likely that preventable deaths are occuring as a protracted result of inadequate preventive health care, particularly essential nutritional care.

Nutritional care is a major part of treatment for most medical problems of the elderly. Nutritional care in health care facilities is sometimes too little too late, especially for Medicaid patients. The patient is discharged before a diet plan can be taught. Few, but increasing, numbers of insurers are covering nutrition services by a dietitian in the home. However, extremely few in-home health care agencies in Texas

employ dietitians to do in-home nutrition services. Many elderly cannot even afford basic physician services and medications. There are reports of homebound clients who will either cut a tablet in half or take one every other day that should be taken daily. The choice is between buying medicine, buying food or paying the rent.

When one considers the high prevalence of chronic disease and need for special diets, the high prevalence of poverty among the elderly, the lack of coordinated long-term care, the increasing numbers of elderly, the prospect of major slashes across the board in both state and federal programs along with local economic conditions that will not permit effective community support, the situation of hunger among the elderly is a timebomb that can be expected to explode silently for the duration of the century without significant federal intervention.

Prepared by: Jan Bassari, M.P.H., R.D., L.D.
Nutrition Specialist
April 14, 1986

Table 1: Numbers of Texas Elderly Receiving Nutrition Services

(Unduplicated Annual Count)**

Funding Source	FY85	FY86***	1990****
OAA Congregate*	185,049	177,092	137,862
OAA Home Delivered*	35,643	31,938	29,534
Omnibus Hunger Act	-0-	6,000	8,000
SSI - Title XX**	4,200	6,000	3,600
Private (Conservative estimate)	25,000	25,000	25,000
Total Rounded Estimate	250,000	246,000	204,000

* Includes USDA Cash and all budgeted matching funds.

** Only monthly caseload figures are collected by Texas Department of Human Services; the unduplicated annual count could be up to 35% higher.

*** Estimates based on 4.3% cuts in federal funds.

**** Estimates based on 25.5% cuts in federal funds and unofficial projected cuts in meals provided under SSI.

Table 2: Numbers of Texas Elderly with Unmet Need for Nutrition Services*

Unmet Need	1984-5	1986	1990**
Home delivered Meals (5/week)	22,000	16,000	19,000
On waiting lists for home delivered delivered meals (5/week)	4,300	4,000	4,700
Meals 7 days per week (2 extra meals) (Estimate 10% Total)	36,000	34,000	37,000
Meals 2 per day, 7 days per week (9 extra meals) (Estimate 5% Total)	18,000	17,000	18,500
Food Assistance for mobile elderly***	118,000	100,000	120,000

(Rounded estimates)

* Extrapolated from key informant survey in 1984 by Texas Department on Aging. These are not statistically valid data, but represent the best guess from comparison of multiple information sources.

** Assuming no cuts in funds and a 21% projected increase in total elderly 60+ between 1985 and 1990.

*** This need requires a variety of food assistance programs, including food pantries, improvements and higher allotments for food stamps, as well as increased numbers of nutrition sites.

C2G:unmet.jb

PREPARED STATEMENT OF LOUIS SULLIVAN, M.D., PRESIDENT AND DEAN, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA AND VICE PRESIDENT, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS, ON BEHALF OF THE NATIONAL HEALTH COALITION FOR MINORITIES AND THE POOR

Mr. Chairman and Members of the Committee, thank you for the opportunity to address the problem of hunger among the elderly in our society.

I am Dr. Louis W. Sullivan, President of the Morehouse School of Medicine in Atlanta, Georgia, Vice President of the Association of Minority Health Professions Schools, and Coordinator of the National Health Coalition for Minorities and the Poor. This national health coalition was formed by the Association of Minority Health Professions Schools and a number of other national organizations having first-hand knowledge of the devastating problems of our nation's poor and minority citizens. Hunger among the elderly is an issue with which the coalition is all too familiar. We believe that many Americans are unaware of the vast dimensions of this problem. To us, there seems to be no other explanation for why so many citizens who have contributed so much to our society, should be left to live the remainder of their lives in hunger.

At a recent national conference on Health Care for the Poor held in Nashville, Tennessee at the Meharry Medical College, it was noted that there is a widening gap in health status among the nation's poor and minorities and the nation's majority population. Further, in August, 1985 a Task Force appointed by the Secretary of the Department of Health and Human Services reported a significant gap in health status among the nation's blacks and other minorities when compared to the nation's white population. The Secretary's task force reported that annually in the black community almost 60,000 excess deaths occur because of the health disparity in the health status. Evidence presented by both of these efforts also indicates that the problem is growing, not getting better. Unfortunately, in the face of this widening disparity, the Reagan Administration proposes to eliminate or severely cut a broad range of the federal programs that provide assistance to the poor and minority populations of the country.

The National Health Coalition for Minorities and the

Poor strongly believes that something can and must be done to rectify this growing disparity. In fact, sensitizing national, state, and local policy-makers and the public to the extent of this desperate situation is a major objective of the National Health Coalition for Minorities and the Poor.

As health professionals, we are particularly concerned about the number of elderly patients with nutritional deficiencies. For example, it has been estimated that at least 65% of the elderly persons admitted to hospitals have serious nutritional deficiencies. Weight loss, dehydration, and malnutrition are only a few of the many problems resulting from inadequate food in-take. For instance, hepatic failure, chronic infections and a number of other diseases are associated with an insufficient food supply. Medical care and treatment becomes extremely costly in that nutritional deficiencies, and the diseases associated with these deficiencies, require weeks and sometimes months to remedy. Consequently, the National Health Coalition for Minorities and the Poor urges that funding for Medicare and Medicaid programs be increased, or at the very least, funded at their current FY1986 levels. Furthermore, the Coalition urges increased funding and support for nutrition assistance programs, such as those contained in the Food Security Act. In addition to improving the quality of life for many Americans, these programs are cost-effective because they minimize the need for recurrent treatment and hospitalization due to illness and disease associated with nutritional deficiencies.

Only by increasing access to medical treatment and nutrition assistance programs for our nation's elderly can we hope to rectify the tragic problem of malnutrition and hunger among our elderly citizens.

Thank you Mr. Chairman, for this opportunity to present our views, and we applaud you for your efforts to address this critical national problem.